Nursing Home Services
Appendices

Appendix 1
UB-92 Claim Form Instructions

Providers must use these billing instructions to avoid denied claims or inaccurate claim payment. Enter all required data on the UB-92 claim form in the appropriate data item. Do not include attachments. UB-92 items are required unless "optional" or "not required" is specified.

These instructions will help you complete a UB-92 claim only for Wisconsin Medicaid. If you need to submit a UB-92 claim to other payers in Wisconsin, you may want to refer to the UB-92 billing manual prepared by the State Unified Billing Committee (SUB-C). The UB-92 billing manual contains important coding information not available in this appendix.

Wisconsin Medicaid recipients receive an identification card when initially enrolled in Wisconsin Medicaid and at the beginning of each following month. Always see this card before providing services. Please use the information exactly as it appears on the identification card to complete the patient information.

Item 1 - Provider Name, Address & Telephone Number
Enter the name, city, state, and zip code of the provider submitting the bill.

Item 2 - WIPRO Assigned Number (not required)

Item 3 - Patient Control Number (optional)
Providers can enter up to 17 characters of the patient's internal office account number. This number will appear on the provider's Remittance and Status Report.

Item 4 - Type of Bill
Enter the bill type code. Nursing homes billing for accommodations must indicate bill type 211, 212, 213, or 214.

Item 5 - Federal Tax Number (not required)

Item 6 - Statement Covers Period (from-through)
Enter the beginning and ending service dates for the period on this bill. Enter both dates in MMDDYY format (example: 010195|013195).

Item 7 - Covered Days
Enter the total number of days services were provided on this bill. Do not include the day of discharge.

Item 8 - Noncovered Days (not required)

Item 9 - Coinsurance Days (required for crossover claims)

Item 10 - Lifetime Reserve Days (not required)

Item 11 - Unlabeled Field (not required)

Item 12 - Patient Name
Enter the recipient's last name, first name, and middle initial exactly as it appears on the identification card.

Item 13 - Patient Address (not required)

Item 14 - Patient Birth Date (not required)

Item 15 - Patient Sex (not required)

Item 16 - Patient Marital Status (not required)

Item 17 - Admission Date
This is the date the recipient was admitted to the provider for inpatient care. Enter the admission date in the MMDDYY format (example: 010195). The date of admission to the nursing home is the first date the recipient enters the facility as an inpatient for the current residency. (Current residency is not interrupted by bedhold days or changes in level of care or payer status.)

Item 18 - Admission Hour (not required)

Item 19 -Type of Admission (not required)

Item 20 - Source of Admission
For bill type 211 and 212, enter the code describing the source of this admission.

Type of Bill Definitions

Type of Bill Code	Description
211	Inpatient nursing home - admit through discharge claim
212	Inpatient nursing home - interim, first claim
213	Inpatient nursing home - interim, continuing claim
214	Inpatient nursing home - interim, last claim

Code Structure for Source of Admission

Code	Title	Description
1	Physician referral	The recipient was admitted to this facility by the recommendation of his or her personal physician.
2	Clinic referral	The recipient was admitted to this facility by the recommendation of this facility's clinic physician.
3	HMO referral	The recipient was admitted to this facility by the recommendation of a health maintenance organization physician.
4	Transfer from a hospital	The recipient was admitted to this facility as a transfer from an acute care facility where the recipient was an inpatient.
5	Transfer from a skilled nursing facility	The recipient was admitted to this facility as a transfer from a skilled nursing facility where the recipient was an inpatient.
6	Transfer from another health facility	The recipient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long-term care facilities, and skilled nursing facility recipients that are at a non-skilled level of care.

7	Emergency room	The recipient was admitted to this facility by the recommendation of this facility's emergency room.
8	Court/law enforcement	The recipient was admitted to this facility by the direction of a court of law, or by the request of a law enforcement agency representative.
9	Information not available	The means by which this recipient was admitted to this facility is not known.

Item 21 - Discharge Hour (not required)

Item 22 - Patient Status
Enter the patient status code as of the "statement covers period" through date (item 6).

Code Structure for Patient Status

Code	Definition
01	Discharged to home or self care (routine discharge).
02	Discharged/transferred to another short-term general hospital for inpatient care.
03	Discharged/transferred to skilled nursing facility (SNF).
04	Discharged/transferred to an intermediate care facility (ICF).
05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution.
06	Discharged/transferred to home under care of organized home health service organization.
07	Left against medical advice or discontinued care.
08	Discharged/transferred to home under care of a home IV provider.
20	Expired.
30	Still patient.

Item 23 - Medical/Health Record Number (optional)
Enter the number assigned to the patient's medical/health record. The medical/health record number is typically used to do an audit of the treatment history. It should not be substituted for the patient control number (item 3).

Items 24-30 - Condition Codes (required, if applicable)
Enter the code identifying a condition related to this claim.

Condition Code Structure for Insurance Codes

Code	Title	Definition
01	Military service related.	Medical condition incurred during military service.

02	Condition is employment related.	Recipient alleges that medical condition is due to environment/events resulting from employment.
03	Patient covered by insurance not reflected here.	Indicates that recipient/recipient representative has stated that coverage may exist beyond that reflected in this bill.
05	Lien has been filed.	Provider has filed legal claim for recovery of funds potentially due to a recipient as a result of legal action initiated by or on behalf of the recipient.

Item 31 - Unlabeled Field (not required)

Items 32-35 - Occurrence Codes and Dates (required, if applicable)

Code Structure for Occurrence Codes and Dates

Code	Title	Definition
01	Auto accident	Code indicating the date of an auto accident.
02	No fault insurance involved -- including auto accident/other	Code indicating the date of an accident including auto or other state has applicable no fault liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/tort liability	Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault liability.
04	Accident/employment related	Code indicating the date of an accident allegedly relating to the patient's employment.
05	Other accident	Code indicating the date of an accident not described by the above codes.
06	Crime victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.

Item 36 - Occurrence Span Code and Date (not required)

Item 37 - Internal Control Number (ICN)/Document Control Number (DCN) (not required)

Item 38 - Responsible Party Name and Address (not required)

Items 39-41 - Value Codes and Amounts (required, if applicable)
Always enter value code 84 ("Medicaid patient liability amount") and the amount of any recipient liability.

Item 42 - Revenue Codes (required, if applicable)
Enter revenue code 001 on the line which has the total charges. This detail must have the total of all charges.

Item 43 - Revenue Description (date of service)
Enter the first date of service billed in MMDDYY format followed by a dash. Then enter the last date of

service being billed in MMDDYY format. If discharged, the last date of service is the discharge date.

Item 44 - HCPCS/Rate
Enter the appropriate accommodation or ancillary procedure code.

Item 45 - Service Date (not required)

Item 46 - Units of Service
Enter the number of days or quantity for each line item. Do not count or include the day of discharge/death for accommodation codes. The sum of the accommodation days must equal the billing period in item 43 and must equal the total days in item 7. For transportation services, enter the number of miles.

Item 47 - Total Charges (by accommodation/ancillary code category)
Enter the total charge for each accommodation and ancillary code. Indicate the total charges with 001 in item 42, the description in "total charges" in item 43, and the sum of all charges.

Item 48 - Noncovered Charges (not required)

Item 49 - Unlabeled Field (not required)

Item 50 - Payer Identification
Enter "T19 WI Medicaid." Identify all health insurance payers (including Medicare) on the identification card. Enter the results of billing each health insurance.

Item 51 - Provider Number
Enter the eight-digit billing provider number.

Item 52 - Release of Information Certification Indicator (not required)

Item 53 - Assignment of Benefits Certification Indicator (not required)

Item 54 - Prior Payments (required, if applicable)
Enter the amount the provider has received toward payment of this bill. If other insurance denied the claim, enter $0.00. (Do not include Medicare payments.) Enter the appropriate insurance indicator in item 84.

Item 55 - Estimated Amount Due (not required)

Item 56 - Unlabeled Field (not required)

Item 57 - Unlabeled Field (not required)

Item 58 - Insured's Name (not required)

Item 59 - Patient's Relationship to Insured (not required)

Item 60 - Certification/Social Security Number/Health Insurance Claim Identification Number
Enter the recipient's 10-digit identification number exactly as it appears on the identification card.

Item 61 - Insured's Group Name (not required)

Item 62 - Insured's Group Number (not required)

Item 63 - Treatment Authorization Code (required, if applicable)
Enter the approved seven-digit prior authorization number for all services requiring prior authorization (e.g.,

ventilator, AIDS, head injury). Do not attach the prior authorization to the claim.

Item 64 - Employment Status Code (not required)

Item 65 - Employer Name (not required)

Item 66 - Employer Location (not required)

Item 67 - Principal Diagnosis Code
Enter the full ICD-9-CM diagnosis code (up to five digits) for the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include "E" codes.

Items 68-75 - Other Diagnosis Codes (optional)
Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.

Item 76 - Admitting Diagnosis
Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

Item 77 - External Cause of Injury Code (E-Code) (not required)

Item 78 - Race/Ethnicity (not required)

Item 79 - Procedure Coding Method Used (not required)

Item 80 - Principal Procedure Code and Date (not required)

Item 81 - Other Procedures Codes and Dates(not required)

Item 82 - Attending Physician ID
Enter the UPIN, eight-digit provider number, Wisconsin medical license number, or name of the attending physician.

Item 83 - Other Physician ID (not required)

Item 84 - Remarks (required, if applicable)
Bill health insurance before billing Wisconsin Medicaid, unless the service does not require health insurance billing, according to Appendix 18a of Part A of the provider handbook. If health insurance is a factor in processing this bill, enter the most appropriate "other insurance" code.

Code	When This Action Took Place
OI-P	PAID in part by other health insurance including HMO or HMP. The amount paid by the health insurance to the provider or insured is indicated on the claim.
OI-D	DENIED by other health insurance following submission of a correct and complete claim or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the health insurer.

OI-Y	YES, the card indicates other coverage but it was not billed for reasons including, but not limited to: ◆ recipient denies coverage or will not cooperate; ◆ the provider knows the service in question is Noncovered by the carrier; ◆ health insurance failed to respond to initial and follow-up claim; or ◆ benefits not assignable or cannot get assignment.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Bill Medicare for covered services prior to billing Wisconsin Medicaid. When the recipient's identification card indicates Medicare coverage, and Medicare does not cover the service, indicate a Medicare disclaimer code.

Code	When This Action Took Place
M-1	**Medicare benefits exhausted.** This code applies when Medicare denied the claim because the recipient's lifetime benefit, spell of illness or yearly allotment of available benefits is exhausted.
M-5	**Provider not Medicare certified.** This code applies when the provider is not required by Wisconsin Medicaid to be Medicare Part A or Part B certified, has chosen not to be Medicare Part A or Part B certified or *cannot* be Medicare Part A or Part B certified.
M-6	**Recipient not Medicare eligible.** This code applies when Medicare denied the claim because there is no record of the recipient's eligibility.
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare actually denies the claim for reasons given on the Medicare remittance advice.
M-8	**Noncovered Medicare service.** This code applies when Medicare was not billed because Medicare does not cover the service at this time. A list of noncovered Medicare services is in Appendix 16 of Part A, the all-provider handbook. Nursing homes must use M-8 for Medicare-eligible recipients who are hospitalized and do not wish to return to a Medicare-covered bed.

Items 85 and 86 - Provider Representative Signature and Date Bill Submitted

Sign and date the claim.

Appendix 2a
UB-92 Claim Form Sample
Straight Wisconsin Medicaid with Medicare Coinsurance Days Claim

APPROVED OMB NO. 0938-0279

1 IM Billing Nursing Home 1 W. Williams Street Anytown, WI 55555 (XXX) XXX-XXXX	2			3 PATIENT CONTROL NO 12345					1 TYPE OF BILL 212
4	5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D	9 C-I D.	10 L-R D.	11	
		070195	073195	31					

12 PATIENT NAME	13 PATIENT ADDRESS
Recipient, Ima A	1 W. Williams Anytown, WI 55555

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	24 CONDITION CODES	31
MMDDYY	F		062195			4		30	99876		

32 CODE	32 OCCURRENCE DATE	33	34 CODE	34 OCCURRENCE DATE	35	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a									A
b									B
									C

38	39 CODE	39 VALUE CODES AMOUNT	40	41 CODE	41 VALUE CODES AMOUNT
a	84	125 00			
b					
c					
d					

42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	070195 - 072495	09		24	0 00		
2	072595 - 073195	20		7	350 00		
3							
4 001	TOTAL CHARGE				350 00		
5							
6							
7							
8							
9							
10							
11	**Do not attach a**						
12	**Medicare Remittance**						
13	**Advice.**						
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							

50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A Med - Medicare				0 00		
B T19 - WI Medicaid	11223344					
C						

57 **DUE FROM PATIENT** ▶

58 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC - ID NO	61 GROUP NAME	62 INSURANCE GROUP NO
A				
B		9876543210		
C				

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A			
B			
C			

67 PRIN. DIAG. CD	68 CODE	OTHER DIAG. CODES 69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 ADM. DIAG. CD	77 E-CODE	78
1508	2800	2765						1508		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID	87654321
	IM Attending Physician
83 OTHER PHYS. ID	
OTHER PHYS. ID	

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
M-7	X IM Authorized	MMDDYY

UB-92 HCFA-1450 **OCR/Original** I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Appendix 2b
UB-92 Claim Form Sample
Medicare Part A Coinsurance Days Claim

APPROVED OMB NO. 0938-0279

IM Billing Nursing Home 1 W. Williams Street Anytown, WI 55555 (XXX) XXX-XXXX	2			3 PATIENT CONTROL NO 12345				1 TYPE OF BILL 212
	5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM 070195	THROUGH 073195	7 COV D 31	8 N-C D	9 C-I D 21	10 L-R D	11

12 PATIENT NAME	13 PATIENT ADDRESS
Recipient, Ima A	1 W. Williams Anytown, WI 55555

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	24 CONDITION CODES	31
MMDDYY	F		062195			4		30	99876		

	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	37
a										A
b										B
36										C

	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
a	09	1,174 00			
b	84	125 00			
c					
d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	120	Semi Private Room			31	4,340 00		
2	250	Pharmacy				222 42		
3	270	Medical Supplies						
4								
5								
6	001	TOTAL CHARGE				4,627 72		
7								
8								
9								
10								
11		**Attach a Medicare**						
12		**Remittance Advice.**						
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								

50 PAYER	51 PROVIDER NO.	SPEC PROG IND	ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A Med - Medicare	55 - 5555	Y	Y			
B T19 - WI Medicaid	11223344					
C						
57	**DUE FROM PATIENT ▶**					

58 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC. - ID NO	61 GROUP NAME	62 INSURANCE GROUP NO
A Recipient, Ima A	01	987654321A		
B		9876543210		
C				

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A			
B			
C			

67 PRIN. DIAG. CD	68 CODE	69 DATE	70 CODE	OTHER DIAG. CODES 71 CODE	72 CODE	73 CODE	74 CODE	75 ADM. DIAG. CD	77 E-CODE	78
1508	2800	2765						1508		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID	87654321
	IM Attending Physician
83 OTHER PHYS. ID	
OTHER PHYS. ID	

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
a	X IM Authorized	MMDDYY
b		
c		
d		

UB-92 HCFA-1450 **OCR/Original** I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Appendix 2c
UB-92 Claim Form Sample
Straight Wisconsin Medicaid Claim with Bedhold Days - Ancillaries

APPROVED OMB NO. 0938-0279

IM Billing Nursing Home 1 W. Williams Street Anytown, WI 55555 (XXX) XXX-XXXX	2			3 PATIENT CONTROL NO 01234567890							212
5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 CONV D	8 M-C D	9 C-I D	10 L-R D	11				
	070195	073195	31								
12 PATIENT NAME Recipient, Im A	13 PATIENT ADDRESS										
14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	24 CONDITION CODES	31
			062195			4		30	99876	01	

	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37
a										A
b										B
										C

	39 CODE	39 VALUE CODES AMOUNT		40	41 CODE	41 VALUE CODES AMOUNT	
a	84	643	81				a
b							b
c							c
d							c

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1		070195 - 071195	21		11	462 00		1
2		071295 - 072095	31		9	302 40		2
3		072195 - 073195	20		11	550 00		3
4		071195	N2		5	50 00		4
5								5
6	001	TOTAL CHARGE				1,364 40		6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23

	50 PAYER	51 PROVIDER NO	OTHER PRV ID	ASSIGN YES	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
A							
B	T19 - WI Medicaid	11223344					
C							
57		DUE FROM PATIENT ▶					

	58 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC - ID NO	61 GROUP NAME	62 INSURANCE GROUP NO
A					
B			9876543210		
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN DIAG CD	68 CODE	69 CODE	OTHER DIAG CODES 70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	76 ADM DIAG CD	77 E-CODE	78
4280	78052	5840	7806					4280		

79 P C	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE			OTHER PROCEDURE CODE	DATE

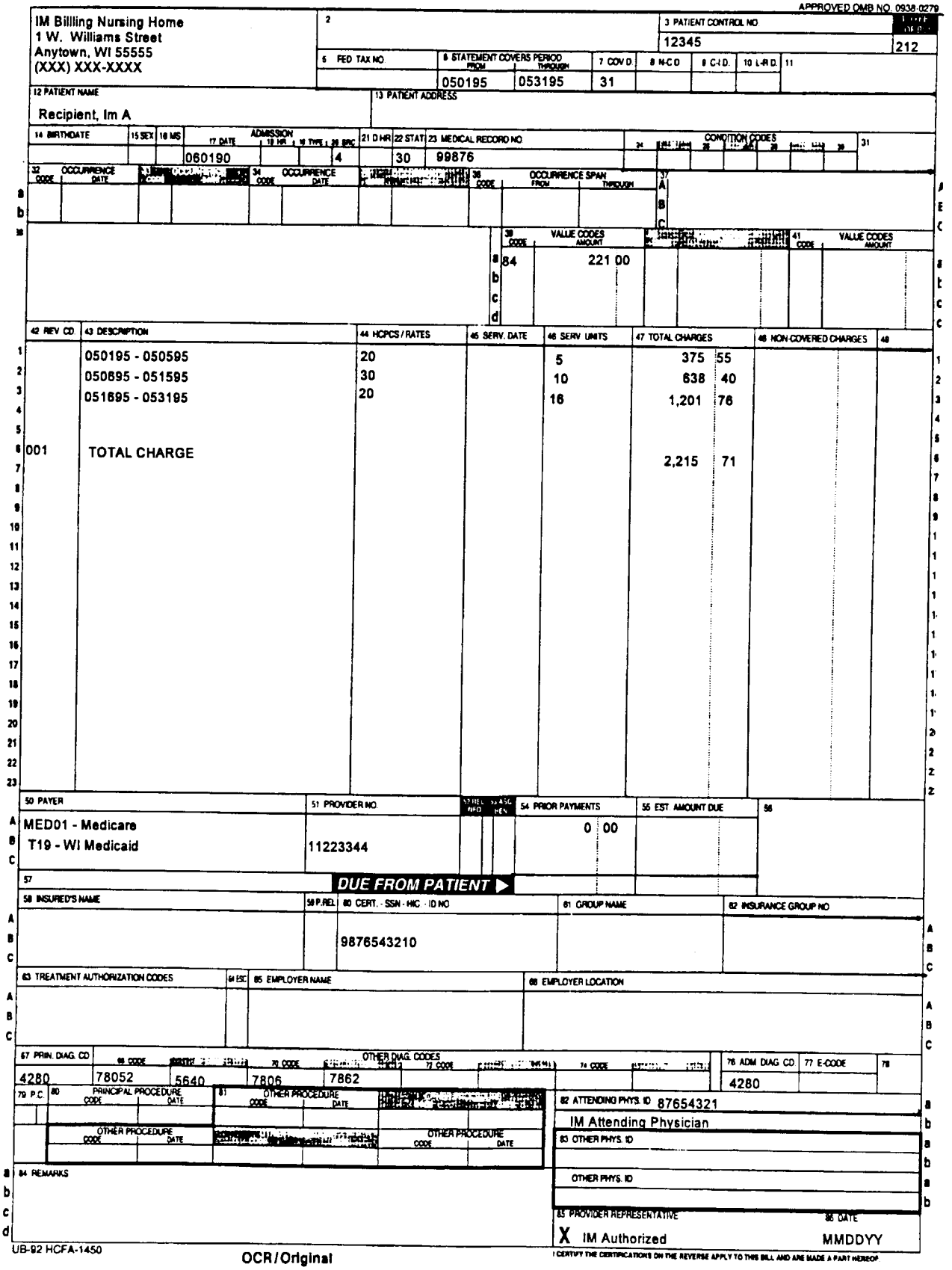
	82 ATTENDING PHYS ID	
a	87654321	a
b	IM Attending Physician	b
a	83 OTHER PHYS. ID	a
b		b
a	OTHER PHYS. ID	a
b		b

	84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
a			
b			
c		X IM Authorized	MMDDYY
d			

UB-92 HCFA-1450 OCR / Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Appendix 2d
UB-92 Claim Form Sample
Straight Wisconsin Medicaid Claim with Bedhold Days



APPROVED OMB NO. 0938-0279

IM Billing Nursing Home
1 W. Williams Street
Anytown, WI 55555
(XXX) XXX-XXXX

3 PATIENT CONTROL NO: 12345 212

5 FED TAX NO | 6 STATEMENT COVERS PERIOD: FROM 050195 THROUGH 053195 | 7 COV'D: 31 | 8 N-C'D | 9 C-I'D | 10 L-R'D | 11

12 PATIENT NAME: Recipient, Im A

13 PATIENT ADDRESS

14 BIRTHDATE | 15 SEX | 16 MS | ADMISSION: 17 DATE 060190, 18 HR, 19 TYPE 4, 20 SRC | 21 D HR | 22 STAT 30 | 23 MEDICAL RECORD NO 99876 | CONDITION CODES 24-30 | 31

32 OCCURRENCE CODE/DATE | 33 | 34 OCCURRENCE CODE/DATE | 35 | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37 A B C

38 VALUE CODES CODE AMOUNT: a 84 221 00; b; c; d | 41 VALUE CODES CODE AMOUNT

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1		050195 - 050595	20		5	375 55		
2		050695 - 051595	30		10	638 40		
3		051695 - 053195	20		16	1,201 76		
4								
5								
6	001	TOTAL CHARGE				2,215 71		
7–23								

50 PAYER: A MED01 - Medicare; B T19 - WI Medicaid; C | 51 PROVIDER NO: 11223344 | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS: 0 00 | 55 EST. AMOUNT DUE | 56

57 | DUE FROM PATIENT ▶

58 INSURED'S NAME: A; B; C | 59 P.REL | 60 CERT. - SSN - HIC - ID NO: 9876543210 | 61 GROUP NAME | 62 INSURANCE GROUP NO

63 TREATMENT AUTHORIZATION CODES: A; B; C | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD: 4280 | OTHER DIAG. CODES: 68 78052, 69 5640, 70 7806, 71 7862, 72, 73, 74 | 76 ADM DIAG. CD: 4280 | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE/DATE | 81 OTHER PROCEDURE CODE/DATE | OTHER PROCEDURE CODE/DATE | OTHER PROCEDURE CODE/DATE

82 ATTENDING PHYS. ID 87654321
IM Attending Physician

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS: a; b; c; d

85 PROVIDER REPRESENTATIVE: X IM Authorized | 86 DATE: MMDDYY

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450 OCR / Original

Appendix 2e
UB-92 Claim Form Sample
Straight Wisconsin Medicaid Claim - Recipient Death

APPROVED OMB NO. 0938-0279

IM Billing Nursing Home 1 W. Williams Street Anytown, WI 55555 (XXX) XXX-XXXX	2			3 PATIENT CONTROL NO 12345					1 TYPE OF BILL 214
5 FED TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 M-C D	9 C-I D.	10 L-R D.	11		
	050195	052495	24						

12 PATIENT NAME Recipient, Im A	13 PATIENT ADDRESS											
14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	24 CONDITION CODES		31
			060190			4		20	99876			

32 OCCURRENCE CODE	OCCURRENCE DATE	33		34 OCCURRENCE CODE	OCCURRENCE DATE				35 CODE	OCCURRENCE SPAN FROM	THROUGH	37	
a												A	
b												B	
												C	

38									39 CODE	VALUE CODES AMOUNT		41 CODE	VALUE CODES AMOUNT
									a	84	221 00		
									b				
									c				
									d				

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1		050195 - 052495	20		24	1,846 44		
2								
3								
4								
5								
6	001	TOTAL CHARGE				1,846 44		
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								

	50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
A							
B	T19 - WI Medicaid	11223344					
C							

57 **DUE FROM PATIENT** ▶

	58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC - ID NO	61 GROUP NAME	62 INSURANCE GROUP NO
A					
B			9876543210		
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD	68 CODE	OTHER DIAG. CODES 70 CODE	72 CODE	74 CODE	76 ADM DIAG. CD	77 E-CODE	78
4280	78052				4280		

79 P.C	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE		82 ATTENDING PHYS. ID	87654321
						IM Attending Physician	
	OTHER PROCEDURE CODE	DATE			OTHER PROCEDURE CODE DATE	83 OTHER PHYS. ID	
a	84 REMARKS					OTHER PHYS. ID	
b							
c						85 PROVIDER REPRESENTATIVE	86 DATE
d						X IM Authorized	MMDDYY

UB-92 HCFA-1450 **OCR/Original** I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Appendix 3
HCFA 1500 Claim Form Instructions for Nursing Home Services

Use these claim form completion instructions to avoid denial or inaccurate claim payment. Enter all required data on the claim form in the appropriate element. Include attachments only when requested. All elements are required unless "not required" is specified.

Medicaid recipients receive an identification card when initially enrolled in Wisconsin Medicaid and at the beginning of each following month. Providers should always see this card before providing services. Please use the information exactly as it appears on the identification card to complete the patient and insured information.

Element 1 - Program Block/Claim Sort Indicator
Enter claim sort indicator "D" (Durable Medical Equipment or Disposable Medical Supplies) or "T" (Therapy services) for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

Element 1a - Insured's ID Number
Enter the recipient's 10-digit identification number as found on the current identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

Element 2 - Patient's Name
Enter the recipient's last name, first name, and middle initial as it appears on the current identification card.

NOTE: A provider may submit claims for an infant if the infant is ten days old or less on the date of service and the mother of the infant is a Medicaid recipient. To bill for an infant using the mother's identification number, enter the mother's last name followed by "Newborn" in element 2. Enter the *infant's* date of birth in element 3. In element 4 enter the mother's name followed by "Mom" in parentheses. Finally, in element 1A enter the mother's ten-digit identification number.

Element 3 - Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the identification card. Specify if male or female with an "X."

Element 4 - Insured's Name (not required)

Element 5 - Patient's Address
Enter the complete address of the recipient's place of residence.

Element 6 - Patient Relationship to Insured (not required)

Element 7 - Insured's Address (not required)

Element 8 - Patient Status (not required)

Element 9 - Other Insured's Name
Health insurance (commercial insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service does not require health insurance billing according to Appendix 18a of Part A of the provider handbook.

- When the provider has billed the health insurance because the "Other Coverage" of the recipient's identification card is blank, the service does not require health insurance billing according to Appendix 18a of Part A of the provider handbook, or the recipient's identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires health insurance billing according to Appendix 18a of Part A of the provider handbook, one of the following codes *must* be indicated in the *first* box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by the health insurance. The amount paid by the health insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by the health insurance following submission of a correct and complete claim or payment was applied towards the coinsurance and deductible. DO NOT use this code unless the claim in question was actually billed to and denied by the health insurer.
OI-Y	YES, the card indicates other coverage but it was not billed for reasons including, but not limited to: ◆ recipient denies coverage or will not cooperate; ◆ the provider knows the service in question is noncovered by the carrier; ◆ health insurance failed to respond to initial and follow-up claim; or ◆ benefits not assignable or cannot get an assignment.

- When "Other Coverage" of the recipient's identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 10 - Is Patient's Condition Related to (not required)

Element 11 - Insured's Policy, Group or FECA Number

This *first* box of this element is used by Wisconsin Medicaid for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing to Wisconsin Medicaid. When the recipient's identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes *must* be indicated. The description is not required.

Code	Description
M-1	**Medicare benefits exhausted**. This code applies when Medicare denied the claim because the recipient's lifetime benefit, spell of illness or yearly allotment of available benefits is exhausted.
M-5	**Provider not Medicare certified**. This code applies when the provider is not required by Wisconsin Medicaid to be Medicare Part A or Part B certified, has chosen not to be Medicare Part A or Part B certified or *cannot* be Medicare Part A or Part B certified.
M-6	**Recipient not Medicare eligible**. This code applies when Medicare denied the claim because there is no record of the recipient's eligibility.
M-7	**Medicare disallowed or denied payment**. This code applies when Medicare actually denies the claim for reasons given on the Medicare remittance advice.
M-8	**Noncovered Medicare service**. This code applies when Medicare was not billed because Medicare does not cover the service at this time. A list of noncovered Medicare services is in Appendix 16 of Part A, the all-provider handbook. Nursing homes must use M-8 for Medicare-eligible recipients who are hospitalized and do not wish to return to a Medicare-covered bed.

If Medicare is not billed because the recipient's identification card indicates no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefit (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A of the provider handbook for further information regarding the submission of claims for dual entitlees.

Elements 12 and 13 - Authorized Person's Signature
(Not required since the provider automatically accepts assignment through certification.)

Element 14 - Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 - If Patient Has Had Same or Similar Illness (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source
When required, enter the referring or prescribing physician's name.

Element 17a - I.D. Number of Referring Physician
When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the Medicaid provider number or license number of the referring provider.

Element 18 - Hospitalization Dates Related to Current Services (not required)

Element 19 - Reserved for Local Use
If an unlisted procedure code is billed, providers may describe the procedure in this element. If there is not enough space for the description, or if multiple unlisted procedure codes are billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

Element 20 - Outside Lab
If a laboratory handling fee is billed, check "yes" to indicate that the specimen was sent to an outside lab. Otherwise, this element is not required.

Element 21 - Diagnosis or Nature of Illness or Injury
The International Classification of Disease (ICD) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 - Medicaid Resubmission (not required)

Element 23 - Prior Authorization
Enter the seven-digit prior authorization number from the approved prior authorization request form. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

Element 24a - Date(s) of Service
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing *only* the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD)

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge *per detail line* in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same emergency indicator.

Element 24b - Place of Service
Enter the appropriate Medicaid *single-digit* place of service code for each service.

Code	Description
7	Nursing Home
8	Skilled Nursing Facility

Element 24c - Type of Service Code
Enter the appropriate single-digit type of service code.

Element 24d - Procedures, Services, or Supplies
Enter the appropriate HCPCS procedure code and, if applicable, a two-character modifier under the "Modifier" column.

Element 24e - Diagnosis Code
When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

Element 24f - Charges
Enter the total charge for each line.

Element 24g - Days or Units
Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed.

Element 24h - EPSDT/Family Planning (not required)

Element 24i - EMG
Enter an "E" for *each* procedure performed as an emergency, regardless of the place of service.

Element 24j - COB (not required)

Element 24k - Reserved for Local Use
Enter the eight-digit provider number of the performing provider *for each procedure*, if it is different that the billing provider number indicated in element 33.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the provider handbook for information on recipient spenddown.

Element 25 - Federal Tax ID Number (not required)

Element 26 - Patient's Account No.
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the fiscal agent Remittance and Status Report.

Element 27 - Accept Assignment
(Not required, provider automatically accepts assignment through Wisconsin Medicaid certification.)

Element 28 - Total Charge
Enter the total charges for this claim.

Element 29 - Amount Paid
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.) Do not enter dollar amounts paid by Medicare.

Element 30 - Balance Due
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier
The provider of the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 - Name and Address of Facility Where Services Rendered

If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit provider number.

Element 33 - Physician's, Supplier's Billing Name, Address, Zip Code and Phone

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit provider number.

Appendix 4
HCFA 1500 Claim Form Sample

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [D] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: IM Prescribing

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V53.9
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 04 01 95	30	8	P	E0410		1	XXX XX	244				
2 05 01 95	31	8	R	W1092		1	XX XX	29				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1324JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $ XX XX

30. BALANCE DUE $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

IM Authorized

MMDDYY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

IM Nursing Home
609 Willow
Anytown WI 55555

PIN# GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix 5
Prior Authorization Request Form (PA/RF) - AIDS

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 134

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555

5 DATE OF BIRTH: MMDDYY

6 SEX: M [x] F [ ]

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
IM Provider
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 12345678

10 DX: PRIMARY: 042.9 - AIDS with ARC

11 DX: SECONDARY: 284.8 - Pancytopenia

12 START DATE OF SOI: n/a

13 FIRST DATE RX: n/a

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
N7		8	E	Private room rate - AIDS	30	$82.00 per day
					TOTAL CHARGE	21 2,460.00

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MMDDYY (DATE) 24 J. M. Requesting (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

[ ] MODIFIED — REASON:

[ ] DENIED — REASON:

[ ] RETURN — REASON:

DATE — CONSULTANT/ANALYST SIGNATURE

Appendix 6
Prior Authorization Physician Attachment (PA/PA) Form

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/PA

PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

① LAST NAME	② FIRST NAME	③ MIDDLE INITIAL	④ MEDICAL ASSISTANCE ID NUMBER	⑤ AGE
Recipient	IM	A	1234567890	36

PROVIDER INFORMATION

⑥ PERFORMING PROVIDER'S NAME	⑦ PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ PERFORMING PROVIDER'S TELEPHONE NUMBER
IM Performing	12345678	(XXX) XXX - XXXX

⑨ REFERRING/PRESCRIBING PHYSICIAN'S NAME: IM Referring

A. Describe diagnosis and clinical condition pertinent to service or procedure requested:

AIDS with ARC. Patient needs assistance with all care. Has healing lesions on upper legs. Is malnourished and dehydrated. He is found to have impairment of his recent and remote memory and it is felt that his insight in judgement were probably organically impaired.

B. Describe medical history pertinent to service or procedure requested:

Was hospitalized in July for 30 days with diagnosis of immunodeficiency virus infection with AIDS-ARC. This was first hospitalization.

C. Supply justification for service or procedure requested:

Drainage and secretion precautions. Blood and body fluid precautions. Patient in isolation. Gown and gloves are worn if in contact with any body secretions. Double bagging linen and using isolation technique for garbage. (Water soluable bags) No special precautions for dietary trays and silverware. Takes by-mouth medication fine. Feeds self regular diet. Encourage fluids. Has healing lesions on legs -- treated with continual moist sterile saline dressings. Patient requires total care. All other placement alternatives have been exhausted and nursing home placement is the most appropriate.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

D. MMDDYY
Date

J. M. Requesting
Requesting Provider's Signature

Appendix 7
Prior Authorization Request Form (PA/RF) Instructions

Element 1 - Processing Type
Enter the appropriate three-digit processing type from the list below. The "process type" is a three-digit code used to identify a category of service requested. *Use 999 - "Other" only if the requested category of service is not found in the list.* Prior Authorization and Spell of Illness requests will be returned without adjudication if no processing type is indicated.

130 - Durable Medical Equipment
132 - Disposable Medical Supplies
134 - AIDS Services (hospital and nursing home)
135 - Ventilator Services (hospital and nursing home)

Element 2 - Recipient's Medicaid Identification Number
Enter the recipient's 10-digit identification number as found on the recipient's identification card.

Element 3 - Recipient's Name
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's identification card.

Element 4 - Recipient's Address
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 - Recipient's Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's identification card.

Element 6 - Recipient's Sex
Enter an "X" to specify male or female.

Element 7 - Billing Provider's Name, Address and Zip Code
Enter the name and complete address (street, city, state, and zip code) of the billing provider. **No other information should be entered in this element since it also serves as a return mailing label.**

Element 8 - Billing Provider's Telephone Number
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the *billing provider.*

Element 9 - Billing Provider's Wisconsin Medicaid Provider Number
Enter the eight-digit provider number of the billing provider.

Element 10 - Recipient's Primary Diagnosis
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis *code and description* most relevant to the service/procedure requested.

NOTE: Pharmacists, medical vendors, and individual medical suppliers may provide a written description only.

Element 11 - Recipient's Secondary Diagnosis
Enter the appropriate ICD-9-CM diagnosis *code and description* additionally descriptive of the recipient's clinical condition.

NOTE: Pharmacists, medical vendors, and individual medical suppliers may provide a written description only.

Element 12 - Start Date of Spell of Illness (not required)

Element 13 - First Date of Treatment (not required)

Element 14 - Procedure Code(s)
Enter the appropriate HCPCS or National Drug Code (NDC) procedure code for each service/procedure/item requested, in this element.

Element 15 - Modifier
Enter the modifier corresponding to the procedure code (if a modifier is required by Wisconsin Medicaid policy and the coding structure used) for each service/procedure/item requested.

Element 16 - Place of Service
Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	Description
7	Nursing Home
8	Skilled Nursing Facility

Element 17 - Type of Service
Enter the appropriate type of service code for each service/procedure/item requested.

Alpha	Description
C	Ancillaries, Hospital and Nursing Home
D	Drugs
E	Accommodations, Hospital and Nursing Home
P	Purchase New DME
R	DME Rental

Element 18 - Description of Service
Enter a written description corresponding to the appropriate HCPCS or National Drug Code (NDC) procedure code for each service/procedure/item requested.

Element 19 - Quantity of Service Requested
Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure/item requested.

Disposable Medical Supplies (number of days supply)
Durable Medical Equipment (number of services)
Hospital and Nursing Home AIDS Services (number of days)
Hospital and Nursing Home Ventilator Services (number of days)

Element 20 - Charges

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1", multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

NOTE: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health and Social Services.

Element 21 - Total Charge

Enter the anticipated total charge for this request.

Element 22 - Billing Claim Payment Clarification Statement

"An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid managed care program at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the managed care program."

Element 23 - Date

Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

Element 24 - Requesting Provider's Signature

The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

Do not enter any information below the signature of the requesting provider -- this space is reserved for the Medicaid consultant(s) and analyst(s).

Appendix 8
Prior Authorization
Durable Medical Equipment Attachment (PA/DMEA) Instructions

Prior authorization determinations are enhanced by complete and high-quality documentation included with the request. Carefully complete this attachment, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Contact the EDS Policy/Billing Correspondence Unit with questions about completing the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization Durable Medical Equipment Attachment (PA/DMEA). The telephone numbers are listed in Appendix 2 of Part A of the provider handbook.

Recipient Information:

Element 1 - Recipient's Last Name
Enter the recipient's last name from the recipient's identification card.

Element 2 - Recipient's First Name
Enter the recipient's first name from the recipient's identification card.

Element 3 - Recipient's Middle Initial
Enter the recipient's middle initial from the recipient's identification card.

Element 4 - Recipient's Medicaid Number
Enter the recipient's 10-digit number from the recipient's identification card.

Element 5 - Recipient's Age
Enter the recipient's age in numerical form (i.e., 45, 60, 21, etc.).

Provider Information:

Element 6 - Prescribing Physician's Name
Enter the name of the prescribing physician in this element.

Element 7 - Prescribing Physician's Medicaid Provider Number
Enter the eight-digit provider number of the physician prescribing the item(s) of durable medical equipment.

Element 8 - Dispensing Provider's Telephone Number
Enter the telephone number, including area code, of the provider *dispensing* the requested DME item.

The remaining portions of this attachment are to be used to document the justification for the requested DME item(s).

1. Complete elements A through H and J for all items of DME requested *except* oxygen equipment.

2. Complete elements A through I if request is for oxygen equipment.

3. Attach a photocopy of the physician's prescription to this attachment. The prescription must be signed and dated within six months of receipt by EDS.

4. Read the Prior Authorization Statement before dating and signing the attachment.

5. The provider requesting/ dispensing the equipment/item must date and sign the attachment .

Appendix 9
Prior Authorization Request Form (PA/RF) - Oxygen

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 130

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890	4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.	
5 DATE OF BIRTH: MMDDYY	6 SEX: M [X] F [ ]
	8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: IM Provider, 1 W. Williams, Anytown WI 55555	9 BILLING PROVIDER NO.: 12345678
	10 DX: PRIMARY: 496 - CPD
	11 DX: SECONDARY: 413.9 - Angina
	12 START DATE OF SOI: n/a
	13 FIRST DATE RX: n/a

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W1092		8	R	Oxygen concentrator	180	XX.XX
					TOTAL CHARGE	21 XX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MMDDYY (DATE) 24 I.M. Requesting (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

[ ] MODIFIED — REASON:

[ ] DENIED — REASON:

[ ] RETURN — REASON:

DATE — CONSULTANT/ANALYST SIGNATURE

Appendix 10
Prior Authorization Durable Medical Equipment Attachment (PA/DMEA) Form

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/DMEA

PRIOR AUTHORIZATION DURABLE MEDICAL EQUIPMENT ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Im	A	1234567890	58

PROVIDER INFORMATION

(6) PRESCRIBING PHYSICIAN'S NAME	(7) PRESCRIBING PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) DISPENSING PROVIDER'S TELEPHONE NUMBER
IM Prescribing	87654321	(XXX) XXX - XXXX

A. Describe the overall physical status of the recipient: (mobility, self-care, strength, coordination)

Mobility: poor
Self-care status: very poor
Strength: very poor
Coordination: poor

B. Describe the medical condition of the recipient as it relates to the equipment/item requested — Why does the recipient need this equipment?

Due to having COPD and angina, patient's ability to breathe is severely impaired to the extent that oxygen at 3 LPM per 12 hours per day was prescribed. The benefit will be to improve breathing of the patient.

C. Is the recipient able to operate the equipment/item requested — ☐ Yes ☒ No — If not, who will do this?

Nursing home staff will operate the equipment.

D. Is training provided or required? ☐ Yes ☒ No Explain:

E. State where equipment/item will be used:

☐ Home (Describe type of dwelling and accessibility)

☒ Nursing Home ☐ School ☐ Office ☐ Job

(Describe accessibility and any special needs)

F. Attach an Occupational or Physical Therapy Report if available.

G. State estimated duration of need: Indefinite

H. If renewal or continuation of DME Authorization is requested, describe the recipient's

- Current clinical condition
- Progress (improvement; no change, etc.)
- Results
- Recipient's use of equipment/item prescribed

I. Indicate amount of oxygen to be administered:

3 Liters per minute	____ Continuous
12 Hours per day	____ PRN
____ Days per week	____ PaO_2

Attach a photocopy of the Physician's Prescription to this Attachment form. The prescription must be signed and dated within 6 months of receipt by EDS.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J. MMDDYY
Date

L. M. Requesting
Requesting Provider's Signature

Appendix 11
Requesting Nursing Home Rate Administrative Review Instructions

The Nursing Home Rate Administrative Review Request form is used to bring *major* problems about nursing home reimbursement to the attention of the Bureau of Health Care Financing (BHCF) Administrative Review Committee. To be considered an acceptable issue for administrative review, all attributes listed below must be adequately addressed. This will require those with a problem to adequately research the issue before transmittal. If more space is required, additional sheets can be submitted. Pertinent correspondence should accompany this transmittal. Nursing homes are expected to send information to their respective associations. The associations, in turn, complete the requested information and documentation as required below.

Following is a description of the attributes:

1. **Statement of Condition**: What is the problem? Outline the problem or state "what is going on."

2. **Criteria**: Why is it a problem? Indicate and cite federal and state statutory requirements or regulations, acceptable business or accounting practices that are being measured against, and provisions of the rate "Methods of Implementation" which are being interpreted.

3. **Cause**: What caused the problem? Cite specific examples.

4. **Effect**: What is the extent of the problem? Be specific. Simple statements without information necessary to determine validity or materiality are inadequate. For collective requests, indicate the number or list homes affected.

5. **Recommendation**: What is the recommended solution? This should be specific and, if possible, address what effect there is on Medicaid costs.

Procedure for Review

1. The BHCF Administrative Review Committee conducts the review, consulting with other members of the BHCF, when appropriate.

2. If a request or recommendation is denied, the rationale for that decision is given to the home.

3. If a rate adjustment is warranted, the regional auditor is notified and adjusts the rate and notifies the home.

Appendix 12
Bureau of Health Care Financing
Nursing Home Rate Administrative Review Request

Nursing Home Name: _____

Provider Number: _____

Date: _____

TO: Bureau of Health Care Financing
Nursing Home Section
Administrative Review Committee
Post Office Box 309
Madison, WI 53701-0309

FROM:
Wisconsin Association of Nursing Homes _____
Wisconsin Association of Homes and Services for the Aging _____
Wisconsin Association of County Homes _____
Nonrepresented Nursing Home _____

SUBJECT OR PROBLEM TITLE: _____

Problem Attributes (see instructions - if insufficient space, attach additional sheets)

1. Statement of Condition:

2. Criteria:

3. Cause:

4. Effect:

5. Recommended Solution:

Appendix 13
Eligibility/Authorization Report

MMEP4490 WISCONSIN - TITLE XIX - ELIGIBILITY DATE - MMDDYY PAGE 1

PRTV NUM	RECIP NAME			RECIP NUMBER	ELIGFM	ELIGTO	AUTHRZED	AUTHFM	AUTHTO	LIAB AMT	LIABFM	LIABTO
12345678	Recipient Resident	Im Ida	A A	1234567890	MMDDYY	MMDDYY	21	MMDDYY	999999	$149.00	MMDDYY	MMDDYY
				1122334455	MMDDYY	MMDDYY	21	MMDDYY	999999	$149.00	MMDDYY	MMDDYY

END OF DATA 000002 RECIPIENTS

Appendix 14
Reading the Eligibility/Authorization Report

Provider Number
This column shows the nursing home's eight-digit provider number.

Recipient Name
This column shows the recipient's last name, first name, and middle initial as it appears on the recipient's identification card.

Recipient Number
This column shows the recipient's 10-digit identification number as it appears on the recipient's identification card.

ELIGFM (Eligibility From)
This column shows the date eligibility was granted (in MMDDYY format) under the recipient's identification number.

ELIGTO (Eligibility To)
This column shows the date (in MMDDYY format) eligibility was terminated under the recipient's identification number.

AUTHRZD (Authorized)
This column shows the last authorized level of care listed on EDS files. The levels of care are listed in Appendix 15 of this handbook.

AUTHFR (Authorization From)
This column shows the date (in MMDDYY format) that the level of care was granted for the recipient.

AUTHTO (Authorization To)
This column shows the date (in MMDDYY format) that the level of care was terminated for the recipient.

Providers must verify:

- The recipient's Medicaid identification number and effective date(s).
- The recipient's level of care and effective date(s).
- The recipient's liability amount and effective date(s).

If the recipient's identification card does not match the information on the eligibility authorization report, the provider must contact the county agency and request an update for the period of eligibility in question. The addresses and telephone numbers of all county agencies are listed in Appendix 8 of Part A of the provider handbook.

Appendix 15
Nursing Home Level of Care/Accommodation Codes

Code	Description	Code	Description
09	Medicare Coinsurance Days	36	DD1A-Hospital Bedhold
20	SNF (Skilled)	37	DD1B-Hospital Bedhold
21	ICF 1 and 2 (Intermediate and Limited)	38	DD2-Hospital Bedhold
22	ICF 3 (Personal)	39	DD3-Hospital Bedhold
23	ICF 4 (Residential)	40	SNF Therapeutic Leave
25	ISN (Intensive Skilled Nursing)	41	ICF Therapeutic Leave
26	DD1A (Developmentally Disabled 1A)	42	Personal Therapeutic Leave
27	DD1B (Developmentally Disabled 1B)	43	Residential Therapeutic Leave
28	DD2 (Developmentally Disabled 2)	45	ISN Therapeutic Leave
29	DD3 (Developmentally Disabled 3)	46	DD1A Therapeutic Leave
30	SNF Hospital Bedhold	47	DD1B Therapeutic Leave
31	ICF Hospital bedhold	48	DD2 Therapeutic Leave
32	Personal Hospital Bedhold	49	DD3 Therapeutic Leave
33	Residential Hospital Bedhold	80	Brain Injured
35	ISN Hospital Bedhold	81	Intensive Brain Injured

Appendix 16
Request for Reimbursement for OBRA Level I Screening

WISCONSIN MEDICAL ASSISTANCE
REQUEST FOR REIMBURSEMENT FOR OBRA LEVEL I SCREENING

Provider Name: _____

Medical Assistance Provider Number: _____

1. Applicant Last Name | Applicant First Name

Social Security Number | Screen Date | Admit (Y/N)

---

2. Applicant Last Name | Applicant First Name

Social Security Number | Screen Date | Admit (Y/N)

---

3. Applicant Last Name | Applicant First Name

Social Security Number | Screen Date | Admit (Y/N)

---

4. Applicant Last Name | Applicant First Name

Social Security Number | Screen Date | Admit (Y/N)

---

5. Applicant Last Name | Applicant First Name

Social Security Number | Screen Date | Admit (Y/N)

---

6. Applicant Last Name | Applicant First Name

Social Security Number | Screen Date | Admit (Y/N)

CERTIFICATION:
This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents or concealment of material fact, may be prosecuted under applicable federal or state laws.

Signature _____ Date _____

Appendix 17
Request for Reimbursement for OBRA Level I Screening Form Instructions

Use these instructions to complete the "Request for Reimbursement for OBRA Level I Screening" form. Reimbursement requests are denied if the following information is not provided..

Provider Name
Enter the name of the facility providing the Level I screening.

Wisconsin Medicaid Provider Number
Enter the eight-digit provider number of the facility providing the Level I screening.

The following information must be provided for each Level I screening completed.

Applicant Last Name
Enter the last name of the applicant receiving a Level I screening.

Applicant First Name
Enter the first name of the applicant receiving a Level I screening.

Social Security Number
Enter the 9-digit Social Security number of the applicant receiving a Level I screening.

Screen Date
Enter the date (in MMDDYY format) that the Level I screening was given.

Admit (Y/N)
Indicate if the recipient was admitted to the facility with a "Y" for yes or "N" for no. A "Y" or "N" must be indicated.

Signature/Date
An authorized representative of the facility must sign and date the request form.

Send Completed Forms To:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Appendix 18
Nurses Aide Training and Competency Evaluation Reimbursement Request Form

WISCONSIN MEDICAL ASSISTANCE
NURSES AIDE TRAINING AND COMPETENCY EVALUATION
REIMBURSEMENT REQUEST

Provider Name: _____

Medical Assistance Provider Number: _____

	Aide Last Name	Aide First Name	Hire Date	Social Security Number	Competency Evaluation	Date of Evaluation	New Aide Training	End Date of New Aide Training
1.								
2.								
3.								
4.								
5.								
6.								

CERTIFICATION:
This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents or concealment of material fact, may be prosecuted under applicable federal or state laws.

_____ _____
Signature Date

Appendix 19
Wisconsin Medicaid
Nurse Aide Training and Competency Evaluation
Reimbursement Request Instructions

Use these instructions to complete the Nurse's Aide Training and Competency Evaluation Reimbursement Request form. Reimbursement requests are denied if the following information is not provided.

Provider Name
Enter the name of the facility employing the nurse's aide.

Wisconsin Medicaid Provider Number
Enter the eight-digit provider number of the facility providing the training or competency evaluation.

The following information must be provided for <u>each</u> nurse's aide receiving training or a competency evaluation.

Aide's Last Name
Enter the last name of the nurse's aide receiving training or a competency evaluation.

Aide's First Name
Enter the first name of the nurse's aide receiving training or a competency evaluation.

Hire Date
Enter the date (in MMDDYY format) the nurse's aide was hired by the facility billing for the training or competency evaluation.

Social Security Number
Enter the nine-digit Social Security number of the nurse's aide receiving training or a competency evaluation.

Competency Evaluation
Check this element if the nurse's aide received a competency evaluation. Only check the "new aide training" element *and* the "competency evaluation" element when the nurse's aide received *both* training and a competency evaluation.

Date of Evaluation
Enter the date (in MMDDYY format) of the competency evaluation. Only indicate a date in "date of new aide training" *and* this element when the nurse's aide received *both* training and a competency evaluation.

New Aide Training
Check this element if the nurse's aide received new aide training. Only check the "new aide training" element *and* the "competency evaluation" element when the nurse's aide received *both* training and a competency evaluation.

Date of New Aide Training
Enter the last date (in MMDDYY format) of the new aide training. Only indicate a date in "date of evaluation" *and* this element when the nurse's aide received *both* training and a competency evaluation.

Signature/Date
An authorized representative of the facility must sign and date the Reimbursement Request form.

Send completed forms to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Appendix 20
Wisconsin Medicaid Allowed Nursing Home Ancillary Codes

Code	Description
N2	Transportation (with name and complete address of destination)
N3	Lab
N4	Radiology
*N6	Private Room
*N7	Ventilator
*N9	AIDS/Symptomatic HIV Positive

Noncovered Medically Necessary Ancillary Codes

Code	Description
M6	Noncovered vision Service (enter specific item/service)
M7	Noncovered Dental Service (enter specific item/service)
M8	Other Noncovered Service (enter specific item/service)

* requires prior authorization

Appendix 21
Bureau of Health Care Financing Regional Offices

Eau Claire Office
Division of Health
312 South Barstow Street
Suite 2
Eau Claire WI 54701-3679
(715) 836-3843

Milwaukee Office
Division of Health
819 North Sixth Street
Room 860
Milwaukee WI 53203
(414) 227-4860

Green Bay Office
Division of Health
200 North Jefferson Street
Suite 211
Green Bay WI 54301-5182
(414) 448-5240

Madison Office
Division of Health
1 West Wilson Street
PO Box 309, Room 265
Madison WI 53701-0309
(608) 267-9595

Central Office
Bureau of Health Care Financing
1 West Wilson Street
PO Box 309, Room 250
Madison WI 53701-0309
(608) 266-2522

Appendix 22
Bureau of Quality Compliance Regional Offices

Eau Claire
Division of Health
Western Regional Office
Bureau of Quality Compliance
312 South Barstow Street
Eau Claire WI 54701
(715) 836-4752

Milwaukee
Division of Health
Southeastern Regional Office
Bureau of Quality Compliance
819 North Sixth Street, Room 875
Milwaukee WI 53203
(414) 227-5000

Green Bay
Division of Health
Northeastern Regional Office
Bureau of Quality Compliance
200 North Jefferson Street
Green Bay WI 54301
(414) 448-5240

Madison
Division of Health
Southern Regional Office
Bureau of Quality Compliance
3514 Memorial Drive
Madison WI 53704
(608) 243-2370

Central BQC Office
1 West Wilson Street
PO Box 309, Room 118
Madison WI 53701-0309
(608) 266-8847

Appendix 23
Minimum Data Set (MDS) Full Assessment Form

Resident Appendix B Numeric Identifier HCFA's RAI Version 2.0 Manual

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME — a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)

2. ROOM NUMBER

3. ASSESSMENT REFERENCE DATE
a. *Last day of MDS observation period* — Month / Day / Year
b. Original (0) or corrected copy of form (enter number of correction)

4a. DATE OF REENTRY — Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) — Month / Day / Year

5. MARITAL STATUS — 1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced

6. MEDICAL RECORD NO.

7. CURRENT PAYMENT SOURCES FOR N.H. STAY (*Billing Office to indicate; check all that apply in last 30 days*)

Medicaid per diem	a.	VA per diem	f.
Medicare per diem	b.	Self or family pays for full per diem	g.
Medicare ancillary part A	c.	Medicaid resident liability or Medicare co-payment	h.
Medicare ancillary part B	d.	Private insurance per diem (including co-payment)	i.
CHAMPUS per diem	e.	Other per diem	j.

8. REASONS FOR ASSESSMENT (*Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed*)

a. Primary reason for assessment
1. Admission assessment (required by day 14)
2. Annual assessment
3. Significant change in status assessment
4. Significant correction of prior assessment
5. Quarterly review assessment
6. Discharged—return not anticipated
7. Discharged—return anticipated
8. Discharged prior to completing initial assessment
9. Reentry
0. *NONE OF ABOVE*

b. *Special codes for use with supplemental assessment types in Case Mix demonstration states or other states where required*
1. *5 day assessment*
2. *30 day assessment*
3. *60 day assessment*
4. *Quarterly assessment using full MDS form*
5. *Readmission/return assessment*
6. *Other state required assessment*

9. RESPONSIBILITY/ LEGAL GUARDIAN (*Check all that apply*)

Legal guardian	a.	Durable power attorney/financial	d.
Other legal oversight	b.	Family member responsible	e.
Durable power of attorney/health care	c.	Patient responsible for self	f.
		NONE OF ABOVE	g.

10. ADVANCED DIRECTIVES (*For those items with supporting documentation in the medical record, check all that apply*)

Living will	a.	Feeding restrictions	f.
Do not resuscitate	b.	Medication restrictions	g.
Do not hospitalize	c.	Other treatment restrictions	h.
Organ donation	d.		
Autopsy request	e.	*NONE OF ABOVE*	i.

SECTION B. COGNITIVE PATTERNS

1. COMATOSE (*Persistent vegetative state/no discernible consciousness*) 0. No 1. Yes (If yes, skip to Section G)

2. MEMORY (*Recall of what was learned or known*)
a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem
b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem

3. MEMORY/ RECALL ABILITY (*Check all that resident was normally able to recall during last 7 days*)

Current season	a.	That he/she is in a nursing home	d.
Location of own room	b.		
Staff names/faces	c.	*NONE OF ABOVE* are recalled	e.

4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING (*Made decisions regarding tasks of daily life*)
0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS (*Code for behavior in the last 7 days.*) [*Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time*].
0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

6. CHANGE IN COGNITIVE STATUS Resident's cognitive status, skills, or abilities have changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING (*With hearing appliance, if used*)
0. *HEARS ADEQUATELY*—normal talk, TV, phone
1. *MINIMAL DIFFICULTY* when not in quiet setting
2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly
3. *HIGHLY IMPAIRED*/absence of useful hearing

2. COMMUNICATION DEVICES/ TECHNIQUES (*Check all that apply during last 7 days*)

Hearing aid, present and used	a.
Hearing aid, present and not used regularly	b.
Other receptive comm. techniques used (e.g., lip reading)	c.
NONE OF ABOVE	d.

3. MODES OF EXPRESSION (*Check all used by resident to make needs known*)

Speech	a.	Signs/gestures/sounds	d.
Writing messages to express or clarify needs	b.	Communication board	e.
		Other	f.
American sign language or Braille	c.	*NONE OF ABOVE*	g.

4. MAKING SELF UNDERSTOOD (*Expressing information content—however able*)
0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

5. SPEECH CLARITY (*Code for speech in the last 7 days*)
0. *CLEAR SPEECH*—distinct, intelligible words
1. *UNCLEAR SPEECH*—slurred, mumbled words
2. *NO SPEECH*—absence of spoken words

6. ABILITY TO UNDERSTAND OTHERS (*Understanding verbal information content—however able*)
0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

7. CHANGE IN COMMUNICATION/ HEARING Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

☐ = When box blank, must enter number or letter
a. = When letter in box, check if condition applies

SECTION D. VISION PATTERNS

1.	VISION	*(Ability to see in adequate light and with glasses if used)* 0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books 1. *IMPAIRED*—sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) a. Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes b. *NONE OF ABOVE* c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

(Code for indicators observed in last 30 days, irrespective of the assumed cause)
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS

a. Resident made negative statements—e.g., *"Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die"*

b. Repetitive questions—e.g., *"Where do I go; What do I do?"*

c. Repetitive verbalizations—e.g., calling out for help, *("God help me")*

d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received

e. Self deprecation—e.g., *"I am nothing; I am of no use to anyone"*

f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others

g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack

h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES

j. Unpleasant mood in morning

k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE

l. Sad, pained, worried facial expressions—e.g., furrowed brows

m. Crying, tearfulness

n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST

o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends

p. Reduced social interaction

2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered
3.	CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

4. BEHAVIORAL SYMPTOMS

(A) *Behavioral symptom frequency in last 7 days*
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) *Behavioral symptom distressfulness in last 7 days*
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)		

5.	CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others a. At ease doing planned or structured activities b. At ease doing self-initiated activities c. Establishes own goals d. Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) e. Accepts invitations into most group activities f. *NONE OF ABOVE* g.
2.	UNSETTLED RELATIONSHIPS	Overt/open conflict with or repeated criticism of staff a. Unhappy with roommate b. Unhappy with residents other than roommate c. Openly expresses conflict/anger with family/friends d. Absence of personal contact with family/friends e. Recent loss of close family member/friend f. Does not adjust easily to change in routines g. *NONE OF ABOVE* h.
3.	PAST ROLES	Strong identification with past roles and life status a. Expresses sadness/anger/empty feeling over lost roles/status b. Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community c. *NONE OF ABOVE* d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL *SELF-PERFORMANCE*—*(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)*

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   —Weight-bearing support
   —Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—*(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)*

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) *Code for most dependent in self-performance and support.* (A) BATHING SELF-PERFORMANCE codes appear below	(A)	(B)
		0. Independent—No help provided		
		1. Supervision—Oversight help only		
		2. Physical help limited to transfer only		
		3. Physical help in part of bathing activity		
		4. Total dependence		
		8. Activity itself did not occur during entire 7 days *(Bathing support codes are as defined in Item 1, code B above)*		
3.	TEST FOR BALANCE (see training manual)	*(Code for ability during test in the last 7 days)* 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help		
		a. Balance while standing		
		b. Balance while sitting—position, trunk control		
4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	*(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury)* (A) *RANGE OF MOTION* 0. No limitation 1. Limitation on one side 2. Limitation on both sides (B) *VOLUNTARY MOVEMENT* 0. No loss 1. Partial loss 2. Full loss	(A)	(B)
		a. Neck		
		b. Arm—including shoulder or elbow		
		c. Hand—including wrist or fingers		
		d. Leg—including hip or knee		
		e. Foot—including ankle or toes		
		f. Other limitation or loss		
5.	MODES OF LOCOMOTION	*(Check all that apply during last 7 days)*		
		Cane/walker/crutch	a.	
		Wheeled self	b.	
		Other person wheeled	c.	
		Wheelchair primary mode of locomotion		d.
		NONE OF ABOVE		e.
6.	MODES OF TRANSFER	*(Check all that apply during last 7 days)*		
		Bedfast all or most of time	a.	
		Bed rails used for bed mobility or transfer	b.	
		Lifted manually	c.	
		Lifted mechanically		d.
		Transfer aid (e.g., slide board, trapeze, cane, walker, brace)		e.
		NONE OF ABOVE		f.
7.	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them 0. No 1. Yes		
8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he/she is capable of increased independence in at least some ADLs		a.
		Direct care staff believe resident is capable of increased independence in at least some ADLs		b.
		Resident able to perform tasks/activity but is very slow		c.
		Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings		d.
		NONE OF ABOVE		e.
9.	CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

SECTION H. CONTINENCE IN LAST 14 DAYS

1.	CONTINENCE SELF-CONTROL CATEGORIES *(Code for resident's PERFORMANCE OVER ALL SHIFTS)*			
		0. *CONTINENT*—Complete control *(includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool)*		
		1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly		
		2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week		
		3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week		
		4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time		
a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed		
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed		
2.	BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days		
		Constipation	b.	
		Diarrhea		c.
		Fecal impaction		d.
		NONE OF ABOVE		e.

3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan	a.	
		Bladder retraining program	b.	
		External (condom) catheter	c.	
		Indwelling catheter	d.	
		Intermittent catheter	e.	
		Did not use toilet room/commode/urinal		f.
		Pads/briefs used		g.
		Enemas/irrigation		h.
		Ostomy present		i.
		NONE OF ABOVE		j.
4.	CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1.	DISEASES	*(If none apply, CHECK the NONE OF ABOVE box)*		
		ENDOCRINE/METABOLIC/NUTRITIONAL		
		Diabetes mellitus	a.	
		Hyperthyroidism	b.	
		Hypothyroidism	c.	
		HEART/CIRCULATION		
		Arteriosclerotic heart disease (ASHD)	d.	
		Cardiac dysrhythmias	e.	
		Congestive heart failure	f.	
		Deep vein thrombosis	g.	
		Hypertension	h.	
		Hypotension	i.	
		Peripheral vascular disease	j.	
		Other cardiovascular disease	k.	
		MUSCULOSKELETAL		
		Arthritis	l.	
		Hip fracture	m.	
		Missing limb (e.g., amputation)	n.	
		Osteoporosis	o.	
		Pathological bone fracture	p.	
		NEUROLOGICAL		
		Alzheimer's disease	q.	
		Aphasia	r.	
		Cerebral palsy	s.	
		Cerebrovascular accident (stroke)	t.	
		Dementia other than Alzheimer's disease	u.	
		Hemiplegia/Hemiparesis		v.
		Multiple sclerosis		w.
		Paraplegia		x.
		Parkinson's disease		y.
		Quadriplegia		z.
		Seizure disorder		aa.
		Transient ischemic attack (TIA)		bb.
		Traumatic brain injury		cc.
		PSYCHIATRIC/MOOD		
		Anxiety disorder		dd.
		Depression		ee.
		Manic depression (bipolar disease)		ff.
		Schizophrenia		gg.
		PULMONARY		
		Asthma		hh.
		Emphysema/COPD		ii.
		SENSORY		
		Cataracts		jj.
		Diabetic retinopathy		kk.
		Glaucoma		ll.
		Macular degeneration		mm.
		OTHER		
		Allergies		nn.
		Anemia		oo.
		Cancer		pp.
		Renal failure		qq.
		NONE OF ABOVE		rr.
2.	INFECTIONS	*(If none apply, CHECK the NONE OF ABOVE box)*		
		Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	
		Clostridium difficile (c. diff.)	b.	
		Conjunctivitis	c.	
		HIV infection	d.	
		Pneumonia	e.	
		Respiratory infection	f.	
		Sepsemia		g.
		Sexually transmitted diseases		h.
		Tuberculosis		i.
		Urinary tract infection in last 30 days		j.
		Viral hepatitis		k.
		Wound infection		l.
		NONE OF ABOVE		m.
3.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	a. _____		
		b. _____		
		c. _____		
		d. _____		
		e. _____		

SECTION J. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	*(Check all problems present in last 7 days unless other time frame is indicated)*		
		INDICATORS OF FLUID STATUS		
		Weight gain or loss of 3 or more pounds within a 7 day period	a.	
		Inability to lie flat due to shortness of breath	b.	
		Dehydrated; output exceeds input	c.	
		Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days	d.	
		OTHER		
		Delusions	e.	
		Dizziness/Vertigo		f.
		Edema		g.
		Fever		h.
		Hallucinations		i.
		Internal bleeding		j.
		Recurrent lung aspirations in last 90 days		k.
		Shortness of breath		l.
		Syncope (fainting)		m.
		Unsteady gait		n.
		Vomiting		o.
		NONE OF ABOVE		p.

2.	PAIN SYMPTOMS	(*Code the highest level of pain present in the last 7 days*) a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (*skip to J4*) 1. Pain less than daily 2. Pain daily	b. INTENSITY of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating
3.	PAIN SITE	(*If pain present, check all sites that apply in last 7 days*)	
		Back pain [a.]	Incisional pain [f.]
		Bone pain [b.]	Joint pain (other than hip) [g.]
		Chest pain while doing usual activities [c.]	Soft tissue pain (e.g., lesion, muscle) [h.]
		Headache [d.]	Stomach pain [i.]
		Hip pain [e.]	Other [j.]
4.	ACCIDENTS	(*Check all that apply*)	
		Fell in past 30 days [a.]	Hip fracture in last 180 days [c.]
		Fell in past 31-180 days [b.]	Other fracture in last 180 days [d.]
			NONE OF ABOVE [e.]
5.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating) [a.]	
		Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem [b.]	
		End-stage disease, 6 or fewer months to live [c.]	
		NONE OF ABOVE [d.]	

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	Chewing problem [a.]	
		Swallowing problem [b.]	
		Mouth pain [c.]	
		NONE OF ABOVE [d.]	
2.	HEIGHT AND WEIGHT	*Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes* a. HT (in.) [ ] [ ] b. WT (lb.) [ ] [ ] [ ]	
3.	WEIGHT CHANGE	a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes	
		b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes	
4.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods [a.]	Leaves 25% or more of food uneaten at most meals [c.]
		Regular or repetitive complaints of hunger [b.]	*NONE OF ABOVE* [d.]
5.	NUTRITIONAL APPROACHES	(*Check all that apply in last 7 days*)	
		Parenteral/IV [a.]	Dietary supplement between meals [f.]
		Feeding tube [b.]	
		Mechanically altered diet [c.]	Plate guard, stabilized built-up utensil, etc. [g.]
		Syringe (oral feeding) [d.]	
		Therapeutic diet [e.]	On a planned weight change program [h.]
			NONE OF ABOVE [i.]
6.	PARENTERAL OR ENTERAL INTAKE	(*Skip to Section L if neither 5a nor 5b is checked*) a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50%	
		b. Code the average fluid intake per day by IV or tube in last 7 days 0. None 3. 1001 to 1500 cc/day 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day	

SECTION L. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night [a.]	
		Has dentures or removable bridge [b.]	
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates) [c.]	
		Broken, loose, or carious teeth [d.]	
		Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes [e.]	
		Daily cleaning of teeth/dentures or daily mouth care—by resident or staff [f.]	
		NONE OF ABOVE [g.]	

SECTION M. SKIN CONDITION

			Number at Stage
1.	ULCERS (Due to any cause)	(*Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.*]	
		a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
2.	TYPE OF ULCER	(*For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4*) a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue	
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
3.	HISTORY OF RESOLVED ULCERS	Resident had an ulcer that was resolved or cured in LAST 90 DAYS 0. No 1. Yes	
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	(*Check all that apply during last 7 days*)	
		Abrasions, bruises	a.
		Burns (second or third degree)	b.
		Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	c.
		Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	d.
		Skin desensitized to pain or pressure	e.
		Skin tears or cuts (other than surgery)	f.
		Surgical wounds	g.
		NONE OF ABOVE	h.
5.	SKIN TREATMENTS	(*Check all that apply during last 7 days*)	
		Pressure relieving device(s) for chair	a.
		Pressure relieving device(s) for bed	b.
		Turning/repositioning program	c.
		Nutrition or hydration intervention to manage skin problems	d.
		Ulcer care	e.
		Surgical wound care	f.
		Application of dressings (with or without topical medications) other than to feet	g.
		Application of ointments/medications (other than to feet)	h.
		Other preventative or protective skin care (other than to feet)	i.
		NONE OF ABOVE	j.
6.	FOOT PROBLEMS AND CARE	(*Check all that apply during last 7 days*)	
		Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems	a.
		Infection of the foot—e.g., cellulitis, purulent drainage	b.
		Open lesions on the foot	c.
		Nails/calluses trimmed during last 90 days	d.
		Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)	e.
		Application of dressings (with or without topical medications)	f.
		NONE OF ABOVE	g.

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	(*Check appropriate time periods over last 7 days*) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:	
		Morning [a.]	Evening [c.]
		Afternoon [b.]	*NONE OF ABOVE* [d.]
(If resident is comatose, skip to Section O)			
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None	
3.	PREFERRED ACTIVITY SETTINGS	(*Check all settings in which activities are preferred*)	
		Own room [a.]	Outside facility [d.]
		Day/activity room [b.]	
		Inside NH/off unit [c.]	*NONE OF ABOVE* [e.]
4.	GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	(*Check all PREFERENCES whether or not activity is currently available to resident*)	
		Cards/other games [a.]	Trips/shopping [g.]
		Crafts/arts [b.]	Walking/wheeling outdoors [h.]
		Exercise/sports [c.]	Watching TV [i.]
		Music [d.]	Gardening or plants [j.]
		Reading/writing [e.]	Talking or conversing [k.]
		Spiritual/religious activities [f.]	Helping others [l.]
			NONE OF ABOVE [m.]

5.	PREFERS CHANGE IN DAILY ROUTINE	*Code for resident preferences in daily routines* 0. No change 1. Slight change 2. Major change a. Type of activities in which resident is currently involved b. Extent of resident involvement in activities

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	*(Record the number of different medications used in the last 7 days; enter "0" if none used)*
2.	NEW MEDICATIONS	*(Resident currently receiving medications that were initiated during the last 90 days)* 0. No 1. Yes
3.	INJECTIONS	*(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)*
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	*(Record the number of DAYS during last 7 days: enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)* a. Antipsychotic b. Antianxiety c. Antidepressant d. Hypnotic e. Diuretic

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—*Check treatments or programs received during the last 14 days* TREATMENTS: Chemotherapy (a.); Dialysis (b.); IV medication (c.); Intake/output (d.); Monitoring acute medical condition (e.); Ostomy care (f.); Oxygen therapy (g.); Radiation (h.); Suctioning (i.); Tracheostomy care (j.); Transfusions (k.); Ventilator or respirator (l.) PROGRAMS: Alcohol/drug treatment program (m.); Alzheimer's/dementia special care unit (n.); Hospice care (o.); Pediatric unit (p.); Respite care (q.); Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) (r.); *NONE OF ABOVE* (s.) b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily)* [Note—count only post admission therapies] (A) = # of days administered for 15 minutes or more; (B) = total # of minutes provided in last 7 days a. Speech - language pathology and audiology services b. Occupational therapy c. Physical therapy d. Respiratory therapy e. Psychological therapy (by any licensed mental health professional)
2.	INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	(Check all interventions or strategies used in last 7 days—no matter where received) Special behavior symptom evaluation program (a.) Evaluation by a licensed mental health specialist in last 90 days (b.) Group therapy (c.) Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage (d.) Reorientation—e.g., cueing (e.) *NONE OF ABOVE* (f.)
3.	NURSING REHABILITATION/ RESTORATIVE CARE	*Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)* a. Range of motion (passive) b. Range of motion (active) c. Splint or brace assistance TRAINING AND SKILL PRACTICE IN: d. Bed mobility e. Transfer f. Walking g. Dressing or grooming h. Eating or swallowing i. Amputation/prosthesis care j. Communication k. Other

4.	DEVICES AND RESTRAINTS	*(Use the following codes for last 7 days:)* 0. Not used 1. Used less than daily 2. Used daily Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising
5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). *(Enter 0 if no hospital admissions)*
6.	EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). *(Enter 0 if no ER visits)*
7.	PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? *(Enter 0 if none)*
8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change. (Enter 0 if none)*
9.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)? 0. No 1. Yes

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes b. Resident has a support person who is positive towards discharge 0. No 1. Yes c. Stay projected to be of a short duration— discharge projected within 90 days (do not include expected discharge due to death) 0. No 2. Within 31-90 days 1. Within 30 days 3. Discharge status uncertain
2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	a. Resident: 0. No. 1. Yes b. Family: 0. No 1. Yes 2. No family c. Significant other: 0. No 1. Yes 2. None
2.	SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:	
	a. Signature of RN Assessment Coordinator (sign on above line)	
	b. Date RN Assessment Coordinator signed as complete	Month — Day — Year
	c. Other Signatures	Title / Sections / Date
	d.	Date
	e.	Date
	f.	Date
	g.	Date
	h.	Date

SECTION S STATE SUPPLEMENTAL ITEMS

1.	RESIDENCE PRIOR TO ADMISSION	Residence prior to admission: (a) State (b) If WI, indicate county	
2.	LOCATION OF SPOUSE	If the resident has a spouse, code the spouse's residence as one of the following: 1. In a nursing home (same or other) 2. In a dwelling the resident and/or spouse owns (i.e., homestead property) 3. Other/unknown living arrangement. If the resident is not married (i.e., never married, widowed, separated, divorced), code the following: 4. All other.	
3.	LEVEL OF CARE	For each resident, code a level of care. (This may be a provisional judgment for initial admissions, private pay residents or residents with a pending determination for a change in level of care). 01. ISN 07. DD 1A 02. SNF 08. DD 1B 03. ICF-1 09. DD 2 04. ICF-2 10. DD 3 05. ICF-3 11. Traumatic Brain Injury 06. ICF-4 12. Ventilator Dependent	

Appendix 24
Minimum Data Set (MDS) Supplemental Assessment Forms

HCFA's RAI Version 2.0 Manual — Appendix B

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1.	DATE OF ENTRY	*Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date* Month — Day — Year
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other
3.	LIVED ALONE (PRIOR TO ENTRY)	0. No 1. Yes 2. In other facility
4.	ZIP CODE OF PRIOR PRIMARY RESIDENCE	
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	*(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)* Prior stay at this nursing home — a. Stay in other nursing home — b. Other residential facility—board and care home, assisted living, group home — c. MH/psychiatric setting — d. MR/DD setting — e. *NONE OF ABOVE* — f.
6.	LIFETIME OCCUPATION(S) (Put "/" between two occupations)	
7.	EDUCATION (*Highest Level Completed*)	1. No schooling 2. 8th grade/less 3. 9-11 grades 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree
8.	LANGUAGE	*(Code for correct response)* a. Primary Language 0. English 1. Spanish 2. French 3. Other b. If other, specify
9.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem? 0. No 1. Yes
10.	CONDITIONS RELATED TO MR/DD STATUS	*(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely)* Not applicable—no MR/DD (Skip to AB11) — a. MR/DD with organic condition Down's syndrome — b. Autism — c. Epilepsy — d. Other organic condition related to MR/DD — e. MR/DD with no organic condition — f.
11.	DATE BACKGROUND INFORMATION COMPLETED	Month — Day — Year

SECTION AC. CUSTOMARY ROUTINE

1.	CUSTOMARY ROUTINE (*In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home*)	*(Check all that apply. If all information UNKNOWN, check last box only)* **CYCLE OF DAILY EVENTS** Stays up late at night (e.g., after 9 pm) — a. Naps regularly during day (at least 1 hour) — b. Goes out 1+ days a week — c. Stays busy with hobbies, reading, or fixed daily routine — d. Spends most of time alone or watching TV — e. Moves independently indoors (with appliances, if used) — f. Use of tobacco products at least daily — g. *NONE OF ABOVE* — h. **EATING PATTERNS** Distinct food preferences — i. Eats between meals all or most days — j. Use of alcoholic beverage(s) at least weekly — k. *NONE OF ABOVE* — l. **ADL PATTERNS** In bed/clothes much of day — m. Wakens to toilet all or most nights — n. Has irregular bowel movement pattern — o. Showers for bathing — p. Bathing in PM — q. *NONE OF ABOVE* — r. **INVOLVEMENT PATTERNS** Daily contact with relatives/close friends — s. Usually attends church, temple, synagogue (etc.) — t. Finds strength in faith — u. Daily animal companion/presence — v. Involved in group activities — w. *NONE OF ABOVE* — x. UNKNOWN—Resident/family unable to provide information — y.

END

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:

a. Signature of RN Assessment Coordinator — Date

b. Signature — Title — Sections — Date

c. — Date

d. — Date

e. — Date

f. — Date

g. — Date

☐ = When box blank, must enter number or letter ☐a. = When letter in box, check if condition applies

Appendix B

HCFA's RAI Version 2.0 Manual

Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME●	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER●	1. Male 2. Female
3.	BIRTHDATE●	Month — Day — Year
4.	RACE/● ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY● AND MEDICARE NUMBERS● [C in 1st box if non med. no.]	a. Social Security Number — — b. Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO.●	a. State No. b. Federal No.
7.	MEDICAID NO. [*-* if pending, "N" if not a Medicaid recipient]●	
8.	REASONS FOR ASSESSMENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior assessment 5. Quarterly review assessment 0. *NONE OF ABOVE* b. *Special codes for use with supplemental assessment types in Case Mix demonstration states or other states where required* *1. 5 day assessment* *2. 30 day assessment* *3. 60 day assessment* *4. Quarterly assessment using full MDS form* *5. Readmission/return assessment* *6. Other state required assessment*
9.	SIGNATURES OF PERSONS COMPLETING THESE ITEMS:	
a. Signatures		Title Date
b.		Date

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

● = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter a ☐ = When letter in box, check if condition applies

MDS QUARTERLY ASSESSMENT FORM

Numeric Identifier _____

A1. RESIDENT NAME — a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)

A2. ROOM NUMBER

A3. ASSESSMENT REFERENCE DATE — a. Last day of MDS observation period (Month — Day — Year)
b. Original (0) or corrected copy of form (enter number of correction)

A4a. DATE OF REENTRY — Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) (Month — Day — Year)

A6. MEDICAL RECORD NO.

B1. COMATOSE — (*Persistent vegetative state/no discernible consciousness*) 0. No 1. Yes (*Skip to Section G*)

B2. MEMORY — (*Recall of what was learned or known*)
a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem
b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem

B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING — (*Made decisions regarding tasks of daily life*)
0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS — (*Code for behavior in the last 7 days.*) [*Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time*].
0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

C4. MAKING SELF UNDERSTOOD — (*Expressing information content—however able*)
0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

C8. ABILITY TO UNDERSTAND OTHERS — (*Understanding verbal information content—however able*)
0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD — (*Code for indicators observed in last 30 days, irrespective of the assumed cause*)
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS
a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"
b. Repetitive questions—e.g., "*Where do I go; What do I do?*"
c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")
d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received
e. Self-deprecation—e.g., "*I am nothing; I am of no use to anyone*"

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (cont.)

VERBAL EXPRESSIONS OF DISTRESS
f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others
g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack
h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions
i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES
j. Unpleasant mood in morning
k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE
l. Sad, pained, worried facial expressions—e.g., furrowed brows
m. Crying, tearfulness
n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST
o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends
p. Reduced social interaction

E2. MOOD PERSISTENCE — One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days
0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered

E4. BEHAVIORAL SYMPTOMS
(A) *Behavioral symptom frequency in last 7 days*
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) *Behavioral symptom alterability in last 7 days*
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

(A) (B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)

G1. (A) ADL SELF-PERFORMANCE—(*Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup*)
0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(A)
a. BED MOBILITY — How resident moves to and from lying position, turns side to side, and positions body while in bed
b. TRANSFER — How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)
c. WALK IN ROOM — How resident walks between locations in his/her room.
d. WALK IN CORRIDOR — How resident walks in corridor on unit.
e. LOCOMOTION ON UNIT — How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair
f. LOCOMOTION OFF UNIT — How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair
g. DRESSING — How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis
h. EATING — How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).

Appendix B
Resident _____

HCFA's RAI Version 2.0 Manual
Numeric Identifier _____

I.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes
J.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)
G2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) *Code for most dependent in self-performance.* (A) BATHING SELF PERFORMANCE codes appear below (A): 0. Independent—No help provided; 1. Supervision—Oversight help only; 2. Physical help limited to transfer only; 3. Physical help in part of bathing activity; 4. Total dependence; 8. Activity itself did not occur during entire 7 days

G4. FUNCTIONAL LIMITATION IN RANGE OF MOTION *(Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury)*
(A) *RANGE OF MOTION*: 0. No limitation; 1. Limitation on one side; 2. Limitation on both sides
(B) *VOLUNTARY MOVEMENT*: 0. No loss; 1. Partial loss; 2. Full loss

	(A)	(B)
a. Neck		
b. Arm—including shoulder or elbow		
c. Hand—including wrist or fingers		
d. Leg—including hip or knee		
e. Foot—including ankle or toes		
f. Other limitation or loss		

G6.	MODES OF TRANSFER	*(Check all that apply during last 7 days)*		
		Bedfast all or most of time	a.	NONE OF ABOVE f.
		Bed rails used for bed mobility or transfer	b.	

H1. CONTINENCE SELF-CONTROL CATEGORIES *(Code for resident's PERFORMANCE OVER ALL SHIFTS)*

0. *CONTINENT*—Complete control *(includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool)*
1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed

H2.	BOWEL ELIMINATION PATTERN	Fecal impaction	d.	NONE OF ABOVE	e.
H3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan	a.	Indwelling catheter	d.
		Bladder retraining program	b.	Ostomy present	f.
		External (condom) catheter	c.	NONE OF ABOVE	j.
I2.	INFECTIONS	Urinary tract infection in last 30 days	k.	NONE OF ABOVE	m.

I3. OTHER CURRENT DIAGNOSES AND ICD-9 CODES *(Include only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood/ or behavior status, medical treatments, nursing monitoring, or risk of death)*
a. _____
b. _____

J1.	PROBLEM CONDITIONS	*(Check all problems present in last 7 days)*			
		Dehydrated; output exceeds input	c.	Hallucinations	i.
				NONE OF ABOVE	p.

J2. PAIN SYMPTOMS *(Code the highest level of pain present in the last 7 days)*
a. FREQUENCY with which resident complains or shows evidence of pain: 0. No pain *(skip to J4)*; 1. Pain less than daily; 2. Pain daily
b. INTENSITY of pain: 1. Mild pain; 2. Moderate pain; 3. Times when pain is horrible or excruciating

J4.	ACCIDENTS	*(Check all that apply)*		Hip fracture in last 180 days	c.
		Fell in past 30 days	a.	Other fracture in last 180 days	d.
		Fell in past 31-180 days	b.	NONE OF ABOVE	e.

J5.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating)		a.
		Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem		b.
		End-stage disease, 6 or fewer months to live		c.
		NONE OF ABOVE		d.
K3.	WEIGHT CHANGE	a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days (0. No; 1. Yes)		
		b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days (0. No; 1. Yes)		
K5.	NUTRITIONAL APPROACHES	Feeding tube		h.
		On a planned weight change program		h.
		NONE OF ABOVE		i.

M1.	ULCERS (Due to any cause)	*(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) (Requires full body exam.)*	Number at Stage
		a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
M2.	TYPE OF ULCER	*(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., Chronic stages 1, 2, 3, 4)*	
		a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue	
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	

N1.	TIME AWAKE	*(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:			
		Morning	a.	Evening	c.
		Afternoon	b.	NONE OF ABOVE	d.

(If resident is comatose, skip to Section O)

N2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time; 1. Some—from 1/3 to 2/3 of time; 2. Little—less than 1/3 of time; 3. None			
O1.	NUMBER OF MEDICATIONS	*(Record the number of different medications used in the last 7 days; enter "0" if none used)*			
O4.	DAYS RECEIVED THE FOLLOWING MEDICATION	*(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)*			
		a. Antipsychotic		d. Hypnotic	
		b. Antianxiety		e. Diuretic	
		c. Antidepressant			

P4.	DEVICES AND RESTRAINTS	*Use the following codes for last 7 days:* 0. Not used; 1. Used less than daily; 2. Used daily
		Bed rails
		a. — Full bed rails on all open sides of bed
		b. — Other types of side rails used (e.g., half rail, one side)
		c. Trunk restraint
		d. Limb restraint
		e. Chair prevents rising
Q2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change; 1. Improved—receives fewer supports, needs less restrictive level of care; 2. Deteriorated—receives more support

R2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)
b. Date RN Assessment Coordinator signed as complete: Month ___ Day ___ Year ___

	Title	Sections	Date
c. Other Signatures			
d.			Date
e.			Date
f.			Date
g.			Date

Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

REENTRY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ⊙	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER ⊙	1. Male 2. Female
3.	BIRTHDATE ⊙	Month — Day — Year
4.	RACE/ ETHNICITY ⊙	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY ⊙ AND MEDICARE NUMBERS ⊙ [C in 1st box if non med. no.]	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ⊙	a. State No. b. Federal No.
7.	MEDICAID NO. ["-" if pending, "N" if not a Medicaid recipient] ⊙	
8.	REASONS FOR ASSESS-MENT	Note—Other codes do not apply to this form a. Primary reason for assessment 9. Reentry
9.	SIGNATURES OF PERSONS COMPLETING FORM	a. Signatures — Title — Sections — Date b. — Date c. — Date

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

4a.	DATE OF REENTRY	Date of reentry Month — Day — Year
4b.	ADMITTED FROM (AT REENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other
6.	MEDICAL RECORD NO.	

⊙ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter ☐a = When letter in box, check if condition applies

Appendix C HCFA's RAI Version 2.0 Manual

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY Numeric Identifier _____

Resident's Name:	Medical Record No.:

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
   - Describe:
     - — Nature of the condition (may include presence or lack of objective data and subjective complaints).
     - — Complications and risk factors that affect your decision to proceed to care planning.
     - — Factors that must be considered in developing individualized care plan interventions.
     - — Need for referrals/further evaluation by appropriate health professionals.
   - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
   - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

A. RAP PROBLEM AREA	(a) Check if triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM	☐		☐
2. COGNITIVE LOSS	☐		☐
3. VISUAL FUNCTION	☐		☐
4. COMMUNICATION	☐		☐
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL	☐		☐
6. URINARY INCONTINENCE AND INDWELLING CATHETER	☐		☐
7. PSYCHOSOCIAL WELL-BEING	☐		☐
8. MOOD STATE	☐		☐
9. BEHAVIORAL SYMPTOMS	☐		☐
10. ACTIVITIES	☐		☐
11. FALLS	☐		☐
12. NUTRITIONAL STATUS	☐		☐
13. FEEDING TUBES	☐		☐
14. DEHYDRATION/FLUID MAINTENANCE	☐		☐
15. DENTAL CARE	☐		☐
16. PRESSURE ULCERS	☐		☐
17. PSYCHOTROPIC DRUG USE	☐		☐
18. PHYSICAL RESTRAINTS	☐		☐

B. _____
1. Signature of RN Coordinator for RAP Assessment Process

2. ☐☐ — ☐☐ — ☐☐☐☐ (Month — Day — Year)

_____
3. Signature of Person Completing Care Planning Decision

4. ☐☐ — ☐☐ — ☐☐☐☐ (Month — Day — Year)

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Key:
- ● = One item required to trigger
- ❷ = Two items required to trigger
- ✱ = One of these three items, plus at least one other item required to trigger
- ③ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL Rehabilitation Trigger A ③	ADL Maintenance Trigger B ③	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	
B2a	Short term memory	1		●																			B2a
B2b	Long term memory	1		●																			B2b
B4	Decision making	1,2,3		●																			B4
B4	Decision making	3					●																B4
B5a to B5f	Indicators of delirium	2	●																	●			B5a to B5f
B6	Change in cognitive status	2	●																	●			B6
C1	Hearing	1,2,3			●																		C1
C4	Understood by others	1,2,3			●																		C4
C6	Understand others	1,2,3		●		●																	C6
C7	Change in communication	2																		●			C7
O1	Vision	1,2,3			●																		O1
O2a	Side vision problems	✓			●																		O2a
E1a to E1p	Indicators of depression, anxiety, sad mood	1,2									●												E1a to E1p
E1n	Repetitive movements	1,2																		●			E1n
E1o	Withdrawal from activities	1,2							●														E1o
E2	Mood persistence	1,2								●	●												E2
E3	Change in Mood	2	●																	●			E3
E4aA	Wandering	1,2,3											●										E4aA
E4aA - E4eA	Behavioral symptoms	1,2,3									●												E4aA - E4eA
E5	Change in behavioral symptoms	1									●												E5
E5	Change in behavioral symptoms	2	●																	●			E5
F1d	Establishes own goals	✓							●														F1d
F2a to F2d	Unsettled relationships	✓							●														F2a to F2d
F3a	Strong id. past roles	✓							●														F3a
F3b	Lost roles	✓							●														F3b
F3c	Daily routine different	✓							●														F3c
G1aA - G1jA	ADL self-performance	1,2,3,4				●																	G1aA - G1jA
G1eA	Bed mobility	2,3,4,8																	●				G1eA
G2A	Bathing	1,2,3,4				●																	G2A
G3b	Balance while sitting	1,2,3																		●			G3b
G6a	Bedfast	✓																	●				G6a
G6a,b	Resident, staff believe capable	✓				●																	G6a,b
H1a	Bowel incontinence	1,2,3,4																	●				H1a
H1b	Bladder incontinence	2,3,4						●															H1b
H2b	Constipation	✓																		●			H2b
H2d	Fecal impaction	✓																		●			H2d
H3c,d,e	Catheter use	✓						●															H3c,d,e
H3g	Use of pads/briefs	✓						●															H3g
I1i	Hypotension	✓																		●			I1i
I1j	Peripheral vascular disease	✓																	●				I1j
I1ee	Depression	✓																		●			I1ee
I1j	Cataracts	✓		●																			I1j
I1l	Glaucoma	✓		●																			I1l
I2j	UTI	✓															●						I2j
I3	Dehydration diagnosis	276.5															●						I3
J1e	Weight fluctuation	✓															●						J1e
J1c	Dehydrated	✓															●						J1c
J1d	Insufficient fluid	✓															●						J1d
J1f	Dizziness	✓													●					●			J1f
J1h	Fever	✓															●						J1h
J1i	Hallucinations	✓																		●			J1i
J1j	Internal bleeding	✓															●						J1j
J1k	Lung aspirations	✓																		●			J1k
J1m	Syncope	✓																		●			J1m

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Key:
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- ✱ = One of these three items, plus at least one other item required to trigger
- ③ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM	CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL Rehabilitation Trigger A ③	ADL Maintenance Trigger B ③	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	MDS ITEM
J1a	Unsteady gait																		●			J1a
J4a,b	Fall													●					●			J4a,b
J4c	Hip fracture																		●			J4c
K1b	Swallowing problem																		●			K1b
K1c	Mouth pain																	●				K1c
K3a	Weight loss	1												●								K3a
K4a	Taste alteration	✓												●								K4a
K4c	Leave 25% food	✓												●								K4c
K5a	Parenteral/IV feeding	✓												●		●						K5a
K5b	Feeding tube	✓													●	●						K5b
K5c	Mechanically altered	✓												●								K5c
K5d	Syringe feeding	✓												●								K5d
K5e	Therapeutic diet	✓												●								K5e
L1a,c,d,e	Dental	✓																●				L1a,c,d,e
L1f	Daily cleaning teeth	None ✓																●				L1f
M2a	Pressure ulcer	2,3,4												●								M2a
M2a	Pressure ulcer	1,2,3,4																	●			M2a
M3	Previous pressure ulcer	1																	●			M3
M4e	Impaired tactile sense	✓																	●			M4e
N1a	Awake morning	✓										❷										N1a
N2	Involved in activities	0										❷										N2
N2	Involved in activities	2,3									●											N2
N5a,b	Prefers change in daily routine	1,2									●											N5a,b
O4a	Antipsychotics	1-7																		✱		O4a
O4b	Anticonvulsants	1-7												●						✱		O4b
O4c	Antidepressants	1-7												●						✱		O4c
O4e	Diuretic	1-7															●					O4e
P4c	Trunk restraint	1,2												●							●	P4c
P4c	Trunk restraint	2																	●			P4c
P4d	Limb restraint	1,2																			●	P4d
P4e	Chair prevents rising	1,2																			●	P4e

Appendix 25
Preadmission Screen/Annual Resident Review
Level I Screen

Division of Health
DOH-2191 (Rev. 6/94)

Bureau of Quality Compliance

PREADMISSION SCREEN/ANNUAL RESIDENT REVIEW (PASARR)
LEVEL I SCREEN

This form is required under sections 42 USC 1936r(b)(3)(F) and 1396r(e)(7) [note: these sections also are referred to as 1919(b)(3)(F) and 1919(e)(7) of the Social Security Act].

PLEASE NOTE

Under these sections, Medicaid certified nursing facilities MUST NOT admit any new resident who is suspected of having a serious mental illness or a developmental disability unless the State mental health authority/State developmental disability authority or designee has evaluated the person and determined if the person needs nursing facility placement and if the person needs specialized services.

Additionally, the Level II evaluations and determinations must be repeated each year for each resident who is suspected of having a serious mental illness or a developmental disability. If a nursing facility admits a resident without completion of the appropriate screen(s), then the facility is in violation of the statutory requirement, which may result in initiation of termination action against the facility.

If a Level II screen is required, then information on this (Level I) form is matched with information from the person's Level II screen to ensure that the facility, the Department's designee and the Department have complied with all applicable federal statutes and regulations. Information on this form will be used for no other purpose.

42 CFR 483.128(a) requires that the resident or his/her legal representative receive a written notice (copy of this front page) if the resident is suspected of having a serious mental illness or a developmental disability.

RESIDENT NAME	DATE OF BIRTH

RESIDENT'S ADDRESS (for preadmission screens only)

NURSING FACILITY	FACILITY ADDRESS

GUARDIAN'S NAME (if applicable)

GUARDIAN'S ADDRESS

GUARDIAN'S TELEPHONE #

(HOME) (WORK)

CHECK ONE:

- ☐ The resident is not suspected of having a serious mental illness or a developmental disability.
- ☐ The resident is suspected of having (check the appropriate box below and forward a copy of this Level I screen to the regional screening agency):
  - ☐ A serious mental illness;
  - ☐ A developmental disability; or
  - ☐ Both a serious mental illness and a developmental disability.

STAFF MEMBER COMPLETING THIS SCREEN (sign after completing pages 1 - 4)		TITLE
TELEPHONE	**DATE SCREEN COMPLETED**	**DATE REFERRED TO SCREENING AGENCY**

INSTRUCTIONS

Federal law requires that all individuals requesting admission to a nursing facility must be screened to determine the presence of a major mental illness and/or a developmental disability. **42 CFR 483.75(l)(5) requires the nursing facility to keep a copy of this form and the results of other preadmission screening(s) in the resident's clinical record.**

Please complete this form by checking the boxes in Sections A, B and C and follow the instructions at the end of each section. Be sure to sign and date the form on the bottom of the front page when you are finished.

PREADMISSION: All individuals seeking admission to a nursing facility must receive a Level I Screen prior to admission.

READMISSION: Individuals who are being readmitted to a Medicaid certified nursing facility after a hospital stay of any type or of any length may be readmitted without completion of another Level I or Level II Screen.

INTERFACILITY TRANSFERS: Residents who are transferred from one nursing facility to another, with or without an intervening hospital stay, are not subject to another Level I or Level II Screen. However, the transferring nursing facility is responsible for ensuring that any PASARR screening reports accompany the transferring resident, and for notifying the Area Screening Agency so that the resident's new location is known for future annual resident reviews.

CHANGE IN STATUS: For those individuals presently residing in a nursing home, this form should be filled out only if there is a change of status in Sections A or B.

SECTION A

QUESTIONS REGARDING MENTAL ILLNESS	YES	NO
1. **CURRENT DIAGNOSIS** Is the individual currently diagnosed as having a major mental illness (such as schizophrenia, paranoia, mood disorder, schizoaffective disorder or atypical psychosis) OR other DSM-IV psychiatric disorder that causes severe functional impairment which precludes independent functioning?		
2. **MEDICATIONS** Within the past six months, has this person been prescribed on a regular basis a major tranquilizer and/or anti-psychotic medication for a major mental health condition when there is no existing organic disorder? If the answer is no, see the note below. If yes, check the YES box to the right and check all prescribed medication(s) on the following list:		

☐ Amitriptyline & Perphenazine /Triavil	☐ Doxepin/Sinequan	☐ Perphenazine/Trilafon
☐ Amitriptyline/Elavil	☐ Fluoxetine/Prozac	☐ Phenelzine/Nardil
☐ Amoxapine/Ascendin	☐ Fluphenazine-Decanoate/Prolixin	☐ Protriptyline/Vivactil
☐ Bupropion/Wellbutrin	☐ Haloperidol/Haldol	☐ Sertraline/Zoloft
☐ Carbamazepine/Tegretol	☐ Imipramine/Tofranil	☐ Thioridazine/Mellaril
☐ Chlorpromazine/Thorazine	☐ Isocarboxazid/Marplan	☐ Thiothixene/Navane
☐ Chlorprothixene/Taractan	☐ Lithium/Lithobid	☐ Tranylcypromine/Parnate
☐ Clomipramine/Anafranil	☐ Loxapine/Loxitane	☐ Trazadone/Desyrel
☐ Clonazepam/Klonopin	☐ Maprotiline/Ludiomil	☐ Trifluoperazine/Stelazine
☐ Clozapine/Clozaril	☐ Mesoridazine/Serentil	☐ Trimipramine/Surmontil
☐ Desipramine/Norpramin	☐ Molindone/Moban	☐ Valproic Acid/Depakene
	☐ Nortriptyline/Pamelor or Aventyl	☐ Other

NOTE: If no major mental illness exists, but one of the above Medications is prescribed, check the "NO" box above and place a notation from the physician in the record identifying the medication and the symptoms and behaviors for which it is prescribed. Note on this form where this information can be found (e.g., see physician's progress note dated 1/1/94).

QUESTIONS REGARDING MENTAL ILLNESS (continued)	YES	NO
3. **SYMPTOMATOLOGY** Is there any presenting manifestation of mental illness, not related to an organic condition, such as: a. Suicidal statements, gestures, or acts?		
b. Hallucinations, delusions, or other psychotic symptoms that pose a serious threat to the safety of the individual or others?		
c. Severe and extraordinary thought or mood disorders that pose a serious threat to the safety of the individual or others?		
QUESTIONS REGARDING DEVELOPMENTAL DISABILITIES	**YES**	**NO**
4. Is there a diagnosis of mental retardation or developmental disability in the individual's past?		
5. Is there any history of mental retardation or developmental disability in the individual's past?		
6. Is there any apparent presenting manifestation (cognitive or behavioral) that may indicate the person has mental retardation or developmental disability?		
NOTE: Wisconsin nursing home rules [HSS-132.51(2)(d)] require that no person who has a developmental disability may be admitted to a nursing facility unless the person requires skilled nursing facility (SNF) services.		

If you have answered no to all the above questions in Section A, the individual does not require further PASARR evaluation. Sign this form and place in the individual's chart. No further action needs to be taken. If you have answered yes to any of the questions, proceed to Section B.

SECTION B

QUESTIONS REGARDING LENGTH OF STAY	YES	NO
The following situations, which are all for short-term admissions, are the only exemptions from Level II Screening.		
1. **HOSPITAL DISCHARGE EXEMPTION - 30 DAY MAXIMUM** Is this individual entering the nursing facility from a hospital (not a psychiatric unit) for the purpose of convalescing from a medical problem for 30 days or less.		
2. **PENDING ALTERNATE PLACEMENT - 30 DAY MAXIMUM** Is this individual entering the nursing facility for a short term stay of 30 days or less while an appropriate placement is located? This individual may be entering the nursing facility from any setting.		
3. **EMERGENCY PLACEMENT - 7 DAY MAXIMUM** Is this individual entering the nursing facility for further assessment in an emergency situation requiring protective services?		
4. **RESPITE CARE - 30 DAYS PER YEAR MAXIMUM** Is this individual entering the nursing facility to provide respite to in-home caregivers to whom the individual is expected to return following a brief nursing facility stay?		

If you have answered yes to any of the items in Section B, the individual may enter the nursing facility with county approval, through the DCS-822 form, for the specified period of time without a referral for a PASARR Level II Screen. Contact the Area Screening Agency to notify them that the person is being admitted and qualifies for an exemption in Section B and forward a copy of the Level I Screen to the Area Screening Agency. If, during the short term stay, it is established that the individual will be staying for a longer period of time than permitted above, the individual must be referred for a Level II Screen.

An individual who entered the facility under the 30-day hospital discharge exemption or pending alternate placement exemption, who is later found to require more than 30 days of nursing facility care must have a Level II Screen Annual Resident Review within 40 calendar days of admission. In those cases the nursing facility must contact the Area Screening Agency so that the Level II Screen can be completed within that time frame.

If you have answered no to the questions in Section B, proceed to Section C.

SECTION C

QUESTIONS REGARDING SEVERE MEDICAL CONDITION	YES	NO
The following questions regarding severe medical condition in conjunction with a major mental illness or developmental disability may indicate that the individual meets the criteria for a categorical determination that specialized services are not required. This information may form the basis for an abbreviated screen.		
1. **TERMINAL ILLNESS** Is this individual terminally ill? (Expected to expire within six months.)		
2. **SEVERE MEDICAL CONDITION**		
Is the individual comatose?		
Is the individual ventilator dependent?		
Is the individual functioning at a brain-stem level?		
Does the individual have a severe medical illness, such as Chronic Obstructive Pulmonary Disease, Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis or Congestive Heart Failure, which result in a level of impairment so severe that the individual could not participate in or benefit from specialized services?		
3. **SEVERE DEMENTIA (including Alzheimer's disease or a related disorder)** Does the individual have a primary diagnosis that results in a level of impairment so severe that the individual could not be expected to participate in or benefit from specialized services? Note: Person's record must show evidence that supports a dementia diagnosis. If Organic Brain Syndrome (OBS) is used as an exemption, it must refer to a primary diagnosis of dementia.		

If you have answered yes to any of the questions in this section, you are required to send to the screening agency, the Level I screen along with available documentation such as tests and other evaluations to verify the condition and the severity of impact the medical condition has on the individual's independent functioning. The screening agency will determine whether the individual meets the criteria for a categorical determination or if a full Level II Screen is warranted. If you have answered no to the questions in this section, proceed to Section D.

SECTION D

REFERRING A PERSON TO THE REGIONAL SCREENING AGENCY

If you have answered "no" to all of the questions in Section A, no further PASARR screening is needed. Complete the signature section on page 1 and retain a copy of this form in the resident's nursing facility medical record.

If you have answered "yes" to any question in Section A and "no" to all of the exemptions listed in Sections B and C, follow these instructions:

- Contact the Area Screening Agency to notify them that the person is being considered for admission and forward a copy of the Level I screen to the Area Screening Agency (a copy must also be maintained in the nursing facility file).
- The Area Screening Agency will perform a Level II Screen for persons with developmental disabilities and/or mental illnesses (regardless of age) and a determination will be made as to whether or not the person needs facility care and if specialized services are required.
- The screening agency will notify the nursing facility and the resident or his/her legal representative, in writing of the determinations made.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH
DOH1104 (C08/92)

STATE OF WISCONSIN

Active Treatment for Mentally Ill Nursing Facility Residents
Roster Claim Form

Facility Name and City _____ Page ___ of ___

Facility Medical Assistance Number _____ Month _____ Year ___

A Resident Name	B Resident's Medical Assistance #	C Date of Admission	D Date of Level II Screen	E Date of Active Treatment Determination *	F Total In-House Days	G Total Supplement Requested **
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.					Page Total	

* Date on the letter sent to the facility from the county or the State Office of Mental Health indicating the need for active treatment.

** Number of in-house days X $9.00

CERTIFICATION:
This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from state funds, and that any false claims, statements, documents or concealment of material fact, may be prosecuted under applicable state laws.

Name and Title _____ Signature _____ Date _____ Phone number for questions _____

Appendix 27
Estate Recovery Affidavit

Department of Health and Social Services
Division of Health
DOH 1113 (4/93)

State of Wisconsin

ESTATE RECOVERY PROGRAM
HEIR INFORMATION

NAME OF DECEASED RESIDENT: _____

SOCIAL SECURITY NO: _____

DATE OF DEATH: _____

AMOUNT IN PERSONAL ACCOUNT: _____

PERSONAL ACCOUNT CONVEYED TO:

_____
(Name of Heir)

_____
(Address of Heir)

_____

AMOUNT CONVEYED: _____

DATE CONVEYED: _____

CONVEYED BY WHOM: _____
(Name)

_____
(Position)

NURSING HOME:

_____
(Name)

_____
(Address)

_____

Mail to:

Wisconsin Department of Health and Social Services
Bureau of Health Care Financing
Coordination of Benefits Unit
P.O. Box 309
Madison, WI 53701-0309

Appendix 28
Estate Recovery Program Notification of Death Form

Department of Health and Social Services
Division of Health
DOH 1113A (4/93)

State of Wisconsin

ESTATE RECOVERY PROGRAM
NOTIFICATION OF DEATH

NAME OF DECEASED RESIDENT: _____

SOCIAL SECURITY NO: _____

DATE OF DEATH: _____

AMOUNT IN PERSONAL ACCOUNT: _____

DOES THE DECEASED HAVE A:
(Please circle appropriate response*)

SURVIVING SPOUSE	NO	UNKNOWN
SURVIVING MINOR CHILDREN	NO	UNKNOWN
SURVIVING DISABLED CHILDREN	NO	UNKNOWN

COMPLETED BY: _____
(Name)

_____
(Position)

NURSING HOME:

_____
(Name)

_____
(Address)

_____

Mail to:

Wisconsin Department of Health and Social Services
Bureau of Health Care Financing
Coordination of Benefits Unit
P.O. Box 309
Madison, WI 53701-0309

* Please do not complete this form if a yes response is appropriate to any of the three questions.